Maternal and Child Health Services
Title V Block Grant

State Narrative for Minnesota

Application for 2011
Annual Report for 2009

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

The signed Assurances and Certifications are available upon request from:

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D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

In Minnesota, the opportunity for public input into the MCH planning process is ongoing, utilizing a variety of methods at both the state and local levels. Minnesota Statutes 145.882 subd. 3, distributes two-thirds of the federal MCH Block Grant by formula to local public health agencies (called Community Health Boards (CHBs)) and specifically limits the use of these funds to programs that address MCH and CYSHCN issues. CHBs report annually to the department on how community input was obtain and used in the process of identifying how federal Title V Block Grant funds will be used in their communities.

CHBs reported for calendar year 2009, that they primarily used community surveys, focus groups, key informant interviews, local MCH advisory groups and community forums to garner public input (attachment). One of the most common issues identified by CHBs was the lack of access in their communities to dental services. With approximately three quarters of the agencies indicating that they responded by working on addressing this issue during the reporting period. Examples of activities include providing fluoride varnish application at EPSDT and WIC clinics, convening community stakeholder groups to address the issue of dental access, and participating with local dentists in Give Kids a Smile Day.

Other opportunities for community input occur at public hearings when annual budgets for public health activities are reviewed and approved, and though dialogue at either community Maternal and Child Health or Public Health Advisory Groups.

The Maternal and Child Health Advisory Task Force (MCHATF) provides a particularly significant source of input. This statutorily required advisory group (Minnesota Statutes 145.881), comprised of 15 members equally representing professionals, representatives from local public health, and consumer representatives, is charged with reviewing and reporting on the health care needs of Minnesota's mothers and children and recommending priorities for funding and activities. The Task Force played a key role in the 2010 MCH Needs Assessment.

In addition, the Commissioner of Health, in consultation with the State Community Health Services Advisory Committee (SCHSAC) and the MCHATF, develops a set of statewide public health measures for the local public health system every five years. SCHSAC is a statutorily (Minnesota Statutes 145A.12, subdivision 7(e)) required advisory group that is charged with providing the Commissioner of Health with recommendation on the development, maintenance, funding, and evaluation of community health services. These statewide local public health objectives are to be based on state and local assessment data regarding the health of Minnesota residents, the essential local public health activities, and Minnesota public health goals. The last set of such measures was developed in 2004 by a SCHSAC work group.

A number of initiatives that have taken place since 2004 will inform the current effort. These include: the establishment of a new local public health measurement reporting system (PPMRS) for Minnesota; the development of national voluntary accreditation standards; the release of County Health Rankings from the University of Wisconsin Population Health Institute measurement project; and the priority needs and measures identified for the Title V Needs Assessment for 2010-2014. Additionally, the MDH is undertaking a strategic planning process to identify goals and key indicators for the Department. The statewide local public health objectives need to fit with and complement these other important projects.

The MCH block grant application and annual plan is available on the Minnesota Department of Health website for review by the general public.

An attachment is included in this section.

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

The Title V Block Grant is the key source of support for promoting the health of mothers and children. The focus of the needs assessment is on MCH target populations: Pregnant Women, Mothers and Infants, Children and Adolescents, and Children and Adolescents with Special Health Care Needs. The needs assessment document outlines the process used to conduct the needs assessment for Minnesota and the resulting priorities and state performance measures for 2011-2015. It also provides an overview of the health of Minnesota's MCH target populations.

Minnesota identified two goals and seven priority needs for the target populations. The priority needs reflect the comprehensive nature of the Title V block grant and the complexity and inter-relatedness of the target populations and include:

Overarching Goal 1: Increase health equity and reduce health disparities for pregnant women, mothers and infants, children and adolescents, and children and youth with special health care needs.
Overarching Goal 2: Focus efforts on activities that result in positive outcomes across the lifespan.
Priority Need 1: Improve Birth Outcomes
Priority Need 2: Improve the Health of Children and Adolescents
Priority Need 3: Promote Optimal Mental Health
Priority Need 4: Reduce Child Injury and Death
Priority Need 5: Assure Quality Screening, Identification and Intervention
Priority Need 6: Improve Access to Quality Health Care and Needed Services
Priority Need 7: Assure Healthy Youth Development

The needs assessment process was designed to address the current needs of the MCH populations in Minnesota and to broadly reflect the comprehensive nature of the Title V block grant. Priorities from the previous needs assessment process were included in the list of potential priorities and considered throughout the process. Many of these priority needs are included in the broader priority needs for the next five years. A table, included in the needs assessment document, shows the 2005-2010 priority needs and their relationship to the 2011-2015 priority needs. Briefly this includes:

Pregnant Women, Mothers, and Infants

2005-10 Priority Need: Promote planned pregnancies and child spacing
Status in 2011-15: Continues in Priority Need 1: Improve Birth Outcomes

2005-10 Priority Need: Eliminate racial and ethnic health disparities in mothers and infants
Status in 2011-15: Continues in Overarching Goal 1: Increase health equity and reduce health disparities for pregnant women, mothers and infants, children and adolescents, and children with special health care needs.

2005-10 Priority Need: Assure early and adequate prenatal care
Status in 2011-15: Continues in Priority Need 1: Improve Birth Outcomes

Children and Adolescents

2005-10 Priority Need: Prevent teen pregnancy and sexually transmitted infections
Status in 2011-15: Continues in Priority Need 1: Improve Birth Outcomes, Priority Need 2: Improve the Health of Children and Adolescents, and Priority Need 7: Assure Healthy Youth Development

2005-10 Priority Need: Prevent child abuse and neglect
Status in 2011-15: Continues in Priority Need 4: Reduce Child Injury and Death

2005-10 Priority Need: Promote mental health for children and adolescents, including suicide prevention
Status in 2011-15: Continues in Priority Need 3: Promote Optimal Mental Health and Priority Need 7: Assure Healthy Youth Development

2005-10 Priority Need: Assure that children and adolescents receive comprehensive healthcare, well child care, immunizations, and dental care
Status in 2011-15: Continues in Priority Need 2: Improve the Health of Children and Adolescents

Children with Special Health Care Needs

2005-10 Priority Need: Improve access to comprehensive mental health screening, evaluation and treatment for CSHSN
Status in 2011-15: Continues in Priority Need 3: Promote Optimal Mental Health and Priority Need 5: Assure Quality Screening, Identification and Intervention

2005-10 Priority Need: Improve early identification of and intervention for CSHCN
Status in 2011-15: Continues in Priority Need 5: Assure Quality Screening, Identification and Intervention

2005-10 Priority Need: Improve access to care and needed services for CSHCN
Status in 2011-15: Continues in Priority Need 6: Improve Access to Quality Health Care and Needed Services

There are numerous changes in program and system capacity since the 2005 needs assessment. Many of these issues are discussed more fully in needs assessment document. Significant changes include:

Family Home Visiting: 2007 legislature amended the Family Home Visiting statute originally passed in 2001 and increased TANF funding to local health departments and tribal governments to support family home visiting services. Evaluation activities have been implemented to monitor progress on home visiting activities. Lastly, new federal legislation will make additional funding available for home visiting

MDH Development and Behavior Clinics: Funding for the Development and Behavior Clinics has been discontinued. MCYSHN staff are support transition of these activities to the appropriate public/private funders and providers.

Health Care Home: The development of health care homes in Minnesota expanded in 2008 as part of the health reform legislation. A primary focus of health care homes is the support of children with special health care needs and their families.

Autism-Related Activities: Minnesota has expanded its focus on autism activities. This includes the development of community collaborative teams to increase screening and evaluation systems.

Local Evaluation and Reporting: Minnesota has expanded it capacity to evaluate and monitor

local public health activities. Through the PPMRS and the implementation of the family home visiting evaluation, Minnesota is better able to report on outcomes of local health department activities on the MCH populations.

III. State Overview

A. Overview

Minnesota is seen as a state where the people enjoy a high quality of life and experience generally better measures of health compared to most other states. Minnesota consistently ranks as one of the most desirable and healthy states in which to live and work. When parents are asked about the overall health status of their child, 91.4 percent report that it is excellent or very good (compared to 84.4 percent nationally). In 2008, nearly 79 percent of Minnesota adults (16-64) were employed, compared to 71 percent in the nation overall. Minnesotans are engaged in their communities; the voter turnout in Minnesota for the 2008 elections was the highest in the nation at 74 percent of the voting-age population casting a ballot and approximately 37 percent of Minnesotans volunteer, which is 10 percentage points higher than the rest of the nation.

Minnesota is however experiencing the same pressing economic challenges being felt across the country. In May 2010, the Minnesota legislature and the Governor agreed on a budget that closed the state's $3 billion shortfall for SFY 2010. While programs for children did receive cuts, the cuts were less than the Governor originally recommended. However, a projected state budget deficit of almost $6 billion for 2012-2013 biennial budgets will again put significant pressures on state funded programs supporting mothers and children.

Demographics Minnesota is a medium-sized state, encompassing slightly more than 84,000 square miles. Minnesota's per capita income in 2008 was $42,772, which ranked thirteen in the country, with the national per capita income of $39,138. The 2009 Minnesota unemployment rate of 8.0 percent was a significant increase from our 2008 rate of 5.4 percent although it compares favorably with the national unemployment rate in 2009 of 9.3 percent. While it remains a major agricultural producer, Minnesota's economy is also driven by service sector industries such as healthcare, manufacturing, financing, insurance, real estate, and wholesale and retail trade. The workforce sustaining this economy comes from a population of 5,220,393 (2008 estimate) people, making Minnesota the 21st most populous state in the nation. More than half of Minnesota's residents live in the 7-county Minneapolis-St. Paul metropolitan area. The Minneapolis-St. Paul area is one of the fastest growing regions in the Midwest and is predicted to continue rapid growth, expecting to reach three million in 2010.

In 2008, there was an estimated 1,406,875 rural Minnesota residents (27 percent of the total Minnesota population). American Indians comprise a significant proportion of the population and cultural heritage of Minnesota. According to the 2000 US Census, 58,192 American Indian or Alaska Natives lived in the state, of these, 32,029 were children. In 2000, approximately half of the American Indian population lived on seven Chippewa and four Dakota reservations, while the remainder lived in major population centers and communities spread across the state.

Minnesota's population is aging. Overall, Minnesota's age distribution is similar to the national average. The three year estimates from the American Community Survey 2006-2008 indicates that sex and age distribution of Minnesota is close to that of the United States. The Minnesota population is estimated at 49.8 percent males and 50.2 percent females which are close to the Unites States estimates of 49.3 and 50.7 percent respectively. Children under the age of five represent 6.8 percent of Minnesota's population (6.9 percent U.S.) with eighteen years and older comprising 75.8 percent of the Minnesota population (75.5 percent U.S.) and individuals over 65 comprising 12.3 percent (12.6 percent U.S.). The median age of Minnesota is 37.1 and the United States median age is 36.7. By 2030, the number of Minnesotans over age 65 is expected to more than double and older adults will comprise about one-fifth of Minnesota's total population.

Demographically, Minnesota had a relatively homogenous racial and ethnic population for most of the twentieth century. This is changing, and although the absolute numbers of populations of color are not large, the rate of change is. Between 2000 and 2008 the state's population of color grew by 32 percent, compared to only 2 percent among whites. About 15 percent of our state's

residents are now persons of color, compared to only about 1 percent in 1960. The 2008 population estimates indicates that 89 percent of Minnesotans are White, 4.6 percent are Black; 1.2 percent American Indian; 3.5 percent Asian; 1.5 percent are of two or more races and 4.1 percent are Hispanic/Latino. Population estimates for children by race in 2007 highlight the changing face of Minnesota in that 78 percent of children were white; 6 percent black; 1 percent American Indian; 5 percent Asian; 3 percent two or more races and 6 percent Hispanic or Latino.

Beginning in the late 1970's Minnesota began to see a new wave of international immigration. Following the end of the war in Vietnam, large numbers of refugees from Southeast Asia began to arrive in Minnesota. After the fall of the Soviet Union in 1991, an increased number of refugees came from Eastern Europe. The hostilities in Bosnia-Herzegovina brought more refugees from what was Yugoslavia. Famine and civil war bring large numbers of refugees from Africa, particularly from Somali. Minnesota's non-profit organizations are welcoming and provide needed services and support to these newcomers, and Minnesota has become a prime destination for refugees. During this same period of time, immigrants came to Minnesota to work in high tech industries. Large numbers of people came from India, China, and Pakistan. These well-educated and well-trained immigrants were hired in the 1990's by the booming technological companies throughout the state. Populations moving to Minnesota from other countries have reached historically high numbers in recent years. In 2008, about 8.7 percent of Minnesota residents were born outside the U.S and among Minnesotans age under 18, approximately 12 percent is foreign-born.

In the most recent data (federal fiscal year 2004) from the Department of Homeland Security and Immigration and Naturalization Service Statistics, 11,708 immigrants came to Minnesota from over 110 different countries. Minnesota's major immigrant populations include: Latinos, Hmong, Somalis, Vietnamese, Russians, Laotians, Cambodians and Ethiopians. Many immigrants also re-home here from other states. The Minnesota State Demographers Office estimates that in 2008, Minnesota saw 15,832 new immigrants, including refugees. The effects on Minnesota have been far reaching with visible changes in our towns and cities, schools and businesses. St. Paul has the largest urban Hmong concentration in the world. Minnesota has the largest Somali population in the United States, most of them living in Minneapolis. More than 80 languages are spoken in the Twin Cities. In 2007, it was estimated that nearly 38 percent of foreign-born Minnesotans were Asian, 25 percent were Latino, 14 percent were European, and 19 percent were African. Approximately 14 percent of Minnesota's total child population (177,000 children), is estimated to live in immigrant families. Among people at least five years old living in Minnesota in 2006-2008, 10 percent spoke a language other than English at home. Of those speaking a language other than English at home 37 percent spoke Spanish.

These significant demographic changes such as the aging of its population, concentration of the population in its metropolitan areas, and rising dependency ratios (elderly and children as a ratio to the working-age population) will impact not only the need for and the type of healthcare, but will also affect housing, education, business, commerce, employers and social services.

Economics - Poverty Overall, one in 10 Minnesotans lived in poverty in 2008 and an estimated 140,000 children (11 percent of children) lived in families whose incomes fell below the federal poverty guidelines. Between 2000 and 2008, the percentage of children living in poverty has grown almost a third. In addition, there are significant racial disparities that exist for children living in poverty. In 2007, Minnesota had the highest poverty rate in the nation for Asian children with 24 percent of Asian children living at or below the poverty line. Children living in single parent families are over nine times more likely to live in poverty than children living in families with married parents. The percent of children born to single mothers in Minnesota has increased from 26 percent in 2001 to 33 percent in 2007. The number of children eligible for free/reduced price school lunch has been increasing steadily over the past two decades and currently thirty-three percent of K-12 children are approved to receive free and reduced price lunches. WIC participation has also increased from 111,717 participants in 2003 to 137,712 in May 2010.

Disparities In the 2009 edition of America's Health Rankings Minnesota was identified as the sixth healthiest state in the nation. Since the annual state health rankings began in 1990, Minnesota has ranked first in health 11 times. While overall, Minnesota enjoys a high level of health, there are significant and highly concerning disparities in health status measures for Minnesota racial and ethnic populations.

•Low birth weight births among African Americans in Minnesota remains two time greater than Whites and low birth weight is higher for American Indians, Asians, and Hispanic/Latinos as compared to Whites.

•Despite a decline in infant mortality rates among American Indian and African Americans in Minnesota, infant mortality rates for these groups are still more than two times higher than the White rate. The five-year average mortality rate for White infants in Minnesota during 2001-2005 was 4.4 per 1,000 infants, the rate for African American infants was 9.2 and for American Indians it was 10.3 per 1,000 infants.

•Women of Color were two to three times more likely and American Indian women seven times more likely to receive inadequate care or no care during their pregnancies than White women in Minnesota.

•Based on 3-year averages, 41% of African American children, 39% of American Indian children, 23% of Asian children, 27% of Hispanic children and 8% of White children under the age of 18 live in poverty in Minnesota.

•In Minnesota, overall 13 percent of WIC participants age 2-4 are overweight. Rates for racial/ethnic populations are: 25 percent American Indian children, 18 percent of Hispanic or Latino children, 16 percent of Asian children, 13 percent African American children and 10 percent White children are overweight.

•In 2009, African Americans were three times more likely to be unemployed than Whites.

•Compared to White children African American children are 5 times more likely and American Indians are 12 times more likely to experience out-of-home care.

•African American population in Minnesota has the highest proportion of CYSHCN at 19.5 percent while Asian and Spanish-speaking Hispanic communities have the lowest percentage at 11.9 percent and 2.6 percent respectively. The White population is in the mid-range at 14.4 percent.

•The teen birth rate for Whites in Minnesota is lower than the U.S. rate. However, for other racial and ethnic groups in Minnesota the teen birth rates are higher than their corresponding U.S. rate. The teen birth rate for Whites is 17.9 per 1,000 and for African Americans 68.4, for American Indian 97.1, for Asian 51.7, and for Hispanic 114.6 per 1,000.

•The rate of uninsurance for the African American population (16 percent); American Indian (18.8 percent); and Hispanic/Latino (29.6 percent) are 2 to 3.7 times higher than the 7.8 percent rate for the white population.

•In 2008, only about seven of 10 Minnesota students graduated on time from high school; less than half of students of color did.

•American Indian death rates are two and a half to three and a half times higher than death rates for Whites for most age groups. Death rates for African Americans are more than one and a half times higher than Whites in most age groups.

•The age-adjusted mortality rate for African Americans due to homicide is 13.5 times higher than the rate for Whites and the rate for AIDS/HIV is 15.7 times the rate for Whites.

•The age-adjusted mortality rate for American Indians due to homicide is 13.3 times the rate for Whites.

Insurance - Access Minnesota ranked third best among all states in the percentage of residents under 65 who had health care coverage in 2008. Results of the 2009 Minnesota Health Access Survey indicate a continued erosion of insurance coverage in Minnesota. Based on the 2001 survey, 5.4 percent of Minnesotans were uninsured. In 2004 this increased to 6.7 percent, in 2007 to 7.2 percent and in 2009 approximately 9.1 percent of Minnesotans, or about 480,000 people did not have health insurance coverage. Of the 480,000 Minnesotans who were uninsured, approximately 85,000 were children under the age of 18. Nearly all of the increase in the number of uninsured that occurred between 2007 and 2009 were among adults. The number

of individuals who had been uninsured for a year or longer increased from 4.6 percent in 2007 to 6.2 percent in 2009. Between 2007 and 2009, there was a significant decline in employer insurance coverage of 62.5 percent to 57.2 percent. This decline in employer-based coverage was identified as the main reason for the increase seen in the uninsurance rate. Despite the potential for access to public program coverage, uninsurance rates for the lowest income groups are all significantly higher than the rate for the state overall. Large health coverage disparities by race and ethnicity in Minnesota continue to exist with uninsurance rates for African American, American Indian and Hispanic/Latino two to 3.7 times higher than for the White population. Not surprising, immigrants in Minnesota were twice as likely as the overall population to be uninsured, Minnesotans living outside the Twin Cities metropolitan area had a higher rate of unisnsurance 10.3 compared to 9.1 for metropolitan residents and individuals who were not married were almost twice as likely as the state population overall to be uninsured. Of particular note is that the rate of uninsurance among college graduates in Minnesota nearly doubled between 2007 and 2009 (from 2.4 percent to 4.5 percent).

State funded health programs in Minnesota provide health insurance coverage for more than 805,000 Minnesotans through three publicly funded health care programs -- Medical Assistance, General Assistance Medical Care (GAMC) and MinnesotaCare. Medical Assistance (MA) is the state's Medicaid program and provides acute, chronic and long-term care services to low-income seniors, children and families, and people with disabilities. In May 2010, 630,780 individuals were enrolled on MA up from 2009 figures of 574,942 a reflection of the economic struggles many families are currently experiencing. Of the individuals on MA, 55 percent are children under age 21. Approximately 6 percent of children receiving MA are eligible because of a disability. In Minnesota, local county agencies determine eligibility for MA within federal and state guidelines. Income eligibility criteria is as follows: pregnant women with incomes at or below 275% of the federal poverty guidelines (FPG); infants under age two with incomes at or below 280% of the FPG; children ages two through 18 at 150% of the FPG; and parents, relative caretakers, and children ages 19 and 20 at or below 100% of the FPG. Most services for this population are through capitated rate contracts with health plans versus a fee for service arrangement. The state currently operates its Medicaid program with one Section 1915(a) waiver, one Section 1915(b) freedom of choice waiver, six Section 1915 (c) home and community-based waivers and Section 1115 waiver. The TEFRA and Home and Community Based Waiver programs allow some children with disabilities to be eligible for MA regardless of parental income. In 2006, the Minnesota Department of Human Services began implementing an 1115 waiver for family planning services. Called the Minnesota Family Planning Program (MFPP), the program provides contraception management services, including STI screening and treatment for individuals age 15 years of age or older and under age 50, who are not eligible for other public programs and who have an income at or below 200 percent of the FPG. Participation in the program does not require the consent of anyone other than the applicant and they may apply at a provider's office for presumptive eligibility. During the presumptive eligibility period the applicant must apply for ongoing eligibility for MFPP or if eligible for MA. The unduplicated count of individuals enrolled in the MFPP in SFY 2009 was 39,271.

General Assistance Medical Care pays for health care services for low-income Minnesotans who are ineligible for MA or other state or federal health care programs. In May 2010 there were 33,534 adults enrolled on GAMC which serves primarily single individuals between the ages 21 and 64 who do not have dependent children and whose income does not exceed 75 percent of FPG. Many of the individuals on GAMC have chronic mental health or chemical dependency problems. The number of current enrollees is significantly less than the number of 36,520 who were enrolled in October 2009, a possible reflection of the confusion recipients experienced as the legislature debated the continuation of the program these past two legislative sessions. As part of the 2010 budget balancing, GAMC was eliminated as of March 2010 and it was proposed that as many individuals as possible be moved to MinnesotaCare.

The 2010 legislature reinstated GAMC before the elimination went into effect, but it underwent massive changes. As of June 1, 2010, GAMC changed from a fee for service program to a

coordinated care delivery system (CCDS). A CCDS is run by a hospital and is responsible for providing and coordinating hospital and non-hospital health care services. Covered services include: inpatient hospital, outpatient hospital, outpatient clinic preventive and some specialty, mental health, medical transportation and medications. The state pays the CCDS an annual fixed dollar amount for the care of the individual. At this time four twin cities metro-area hospitals have established themselves as CCDS and are available to provide service for individuals on GAMC. However, this leaves a number of outstate Minnesotans having to travel hundreds of miles to the Twin Cities to get preventive and acute care.

MinnesotaCare is Minnesota's publicly subsidized program for Minnesotans who do not have access to affordable health care coverage and are not eligible for enrollment in Medical Assistance. In May 2010, there were 141,070 individuals enrolled in the program with 30 percent being children under age 21. MinnesotaCare is funded by a state tax on Minnesota hospitals and health care providers, federal Medicaid matching funds and enrollee premiums. All health services are provided through health plans. There is a monthly premium required for most families - determined by a sliding-fee scale based on family size and income.

MinnesotaCare legislation included erosion or crowd-out barriers consisting of essentially three eligibility provisions. First, children, families and pregnant women must be permanent residents; families without children must not only be permanent residents, but also must have resided in the state for six months prior to enrollment. Second, individuals cannot have had other health coverage for four months prior to enrollment except for children in families with income at or less than 150 percent of FPG or for individuals making a transition to MinnesotaCare from MA or GAMC. The third eligibility provision denies, with certain exceptions, eligibility for individuals who have had access to employer subsidized insurance (50 percent or more of premium cost) through a current employer in the 18 month period prior to enrollment in the MinnesotaCare program.

Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas (MUAs) are areas that are federally designated as lacking adequate health care services. Populations in 45 counties out of the total 87 Minnesota counties are in federally designated Health Professional Shortage Areas (HPSAs) for primary care. Additionally, populations in 41 counties are in dental HPSAs and populations in 70 counties are in mental health HPSAs. While some of these designations are in urban areas such at St. Paul and Minneapolis with high percentages of poverty and minority populations, the majority are located in frontier and rural counties in the state. These areas tend to lack employment opportunities and experience a higher rate of uninsurance than other areas in the state.

HPSAs and MUAs help meet the health care needs of medically underserved rural and urban populations of Minnesota by supporting the health care safety net services. Clinics located in these areas and providing health care services to underserved population can meet eligibility criteria for a number of federal and state assistance programs, including grants and reimbursement incentive programs. Community Health Centers in Minnesota collectively serve 180,000 patients per year--38 percent of them uninsured, 43 percent in public insurance programs and 6 percent on Medicare. The current economy is expected to provide additional stress on this system as more unemployed individuals seek low cost medical services.

STATE LEVEL INITIATIVES

Early Childhood Governor Pawlenty under Executive Order 08-14 created the State Advisory Council on Early Childhood Education and Care in September of 2008. This was in response to federal provisions in the Improving Head Start for School Readiness Act of 2007. In addition to federal responsibilities outlined in Public Law 110-134 the Early Childhood Advisory Council was charged with making recommendations on the most efficient and effective way to leverage state and federal funding streams for early childhood and child care programs; how to coordinate or collocate early childhood and child care programs in one state Office of Early Learning; to review program evaluations regarding high-quality childhood programs; and to propose legislation on

how to most effectively create a high quality early childhood system in Minnesota in order to improve the educational outcomes of children so that all children are school-ready by 2020. While the Department of Health did not have a membership on the Council, Title V staff along with staff from our federally funded Early Childhood Systems grant participated on a number of work groups. During the 2010 legislative session a number of small but meaningful changes was made to Minnesota's early care and education system. Legislation required that a representative from the Minnesota Department of Health be added to the Council. The Governor's Early Childhood Advisory Council was also directed to 1) create and implement a statewide school readiness report card and to examine current practices and make recommendations for expanding assessments and screenings to more children at younger ages 2) explore how Minnesota can improve screening and assessment of young children and 3) establish a task force of the Council to explore coordinating or co-locating early childhood programs in a state Office of Early Learning. The School Readiness Funders Coalition, which supported these legislative provisions, has agreed to provide $158,000 in private funds to assist the Council in this work.
Health Care Reform

In May 2008, Governor Pawlenty signed significant health care reform legislation into law. This comprehensive health reform package laid the groundwork toward achieving quality, affordable and accessible health care for all Minnesotans and set into place reforms in four broad areas: 1) population health with the goal of investing in public health to help Minnesotans live longer better, healthier lives by reducing the burden of chronic disease. Approximately $47 million dollars in the fall of 2009 were awarded to 39 communities to address obesity and tobacco use in Minnesota residents. These awards covered 86 counties (out of 87) and eight (out of 11) tribal governments. Efforts will utilize policy, systems and environmental changes in four settings: schools, work sites, health care and community to tackle the top three causes of preventable illness and death: tobacco use, physical inactivity and poor nutrition; 2) market transparency and enhanced information with the goal of providing public reporting of health care costs and quality information that will allow providers, purchasers, policy makers and consumers to make better decisions about health and health care delivery; 3) payment reform with the goal to promote quality outcomes; and 4) the development of health care homes in which primary care providers, families and patients work in partnership to improve health outcomes and quality of life for individuals with chronic health conditions and disabilities. The legislation includes payment to primary care providers for partnering with patients and families to provide coordination of care. Minnesota Statutes SS256B.0751, subd.2, directed the Minnesota Department of Health (MDH) and the Minnesota Department of Human Services (DHS) to develop and implement standards of certification for health care homes for state health care programs. The MDH and DHS published the adopted rule related to health care homes on January 11, 2010. This adopted rule carries out these directions by developing and implementing the standards. It also spells out the procedures for certification and re-certification of health care homes. The rule became effective when it was published and the Department of Health is in the process of certifying health care homes.

TITLE V PROGRAM ROLE
The role of the Title V program in the state's health care delivery environment is to assess the health needs of mothers, children, and their families and to use that information to effectively advocate on their behalf in the development of policies concerning organizational and operational issues of health systems, and to advocate for services and funding streams which have the potential to improve their health. The state's Title V program does have a significant assurance role. The Title V program areas of MCH and CYSHCN administer, coordinate and support many activities addressing maternal and child health, including the Title V Block Grant activities. The maternal and child health responsibilities include statewide planning and coordination of services through the acquisition and analysis of population-based data, the provision of technical support and training; coordination of various public and private efforts; and support for targeted preventive health services in communities with significant populations of high risk and low income families.

Program goals described in a later section are accomplished through partnerships with both state and local level agencies. The Department has interagency agreements with the Department of

Human Services and the Department of Education related to Title V/Title XIX activities, and also partners with local Community Health Boards (local public health entities), the Minnesota Department's of Economic Security, Corrections, and Public Safety. Along with many other institutions of higher education, Minnesota is fortunate to have an excellent School of Public Health at the University Of Minnesota's Twin Cities campus. The close working relationship with this school, particularly with the MCH and nursing programs provides resources for both members of this partnership and future MCH practitioners.

CURRENT DEPARTMENTAL PRIORITIES/INITIATIVES
As the Minnesota Department of Health positions itself for the next two to five years, legislative and gubernatorial direction as well as community- and population-based health issues will shape its priorities. The current governor, Tim Pawlenty, has identified health reform as one of the state's priorities and charged MDH with significant responsibilities in its implementation plan.

The MDH administration, through the Health Steering Team (HST), made up of the Executive Office staff and Division Directors, strategic planning activities in 2007 identified four priority focus areas: Emergency Preparedness; Health Disparities; Preparing for an Aging Population and Health Care System Reform. In 2010, the department once again entered into a strategic planning process. A result was that while Emergency Preparedness continues to be a critical issue, significant progress had been made and that it could now be retired as a priority focus area. Two other new strategic priorities were identified, reducing obesity and tobacco use and "Investing in Our Children".

The goal of "Investing in Our Children is to direct the department's child health resources toward promoting the optimal health and wellbeing of Minnesota's children and to ensure that these resources are well targeted, well coordinated, and achieving the desired outcomes. The focus on the first phase of the initiative was on current MDH policy and programs whose services address the needs of infants and children, prenatally through age 24. Key staff from all Divisions who administer child health programs came together for a two day "event" to 1) recommend key childhood objectives for the department; 2) to recommend how the department could strengthen child health efforts; and 3) to recommend how the department could sustain a coordinated approach to children's health issues.

Recommendations from Phase 1 were forwarded to the commissioner of health at the end of June. In July, approval to implement Phase 2 was obtained. Phase 2 activities will begin in early August and include: 1) convene an internal Children's Health Council to guide the work of the Initiative, 2) recommend key indicators of child health to monitor MDH progress in improving the health status of children, 3) develop an MDH Child Health Strategic Action Plan that will recommend processes and approaches by which MDH will: enhance program and partner collaborations; coordinate partnerships with their state agencies who contribute to children's health; identify priority strategies for addressing health disparities in children; identify opportunities to integrate services; eliminate overlaps and gaps in activities; 4) develop SMART child health objectives for the department, 4) conduct a "Kaizen" event to focus communications strategically including key child health messages to be used by child health programs to support each other, 5) select one to two child health objectives for further development; establish cross-divisional teams to develop department wide work plans identifying specific activities that will assist MDH in reaching these objectives, and 6) propose a variety of methods for engaging a wide range of partners in discussions about child health issues including, brown bag lunches, webinars, conferences and or a Child Health Summit. Title V staff play a key role in this initiative and the 2010 MCH Needs Assessment will help shape the work of this cross-department activity.

Decision-making Process There are a number of institutionalized forums that allow the Commissioner of Health, the Community and Family Health Division Director and the Title V Directors to remain up-to-date on the social, political and economic dynamics affecting health care issues. All of the groups described below provide for a statewide perspective of various

stakeholders on different policy issues, which affords a number of different vehicles for defining problems and policy and for providing feedback on recently enacted policy.

1. The Health Steering Team (HST) HST consists of the health department's Executive Office staff and the department's highest managers, the Division Directors. It meets bi-monthly to provide input into departmental policies, determine priorities, and to identify and resolve issues.

2. Bureau Leadership Meeting are monthly meetings of the Assistant Commissioner of the Community and Family Health Promotion Bureau and the Directors of the four areas she oversees: Community and Family Health Division; Health Promotion and Chronic Disease; Office of Minority and Multicultural Health and the Office of Statewide Health Improvement Initiatives. These meetings discuss cross division issues and help assure that coordinated and effective strategies are implemented.

3. The Maternal and Child Health Advisory Task Force (MCHATF) is a statutorily created standing advisory committee that assists the Commissioner of Health on selected policy issues. It is a 15-member group equally represented by consumers, maternal and child health professionals, and community health agency members with ex-officio representation from the Minnesota Department of Human Services; the Minnesota Department of Education; and the University of Minnesota MCH Program. Its purpose is to advise the Commissioner, the Division Director and the Title V program on the health status and health care needs of mothers and children. Workgroups are established to work on key issues of maternal and child health importance. In the fall of 2010 the advisory task force will be convening a Children's Mental Health Promotion Work Group to make recommendations on defining the role of state and local public health in children's mental health promotion and develop strategies to implement action around this issue.

4. The State Community Health Services Advisory Committee (SCHSAC) is a standing advisory committee comprised of county commissioners and local community health administrators. It meets at least four times a year and its purpose is to advise the Commissioner of Health on all matters relating to the development, maintenance, funding and evaluation of the local public health system. Each year the SCHSAC forms 3-5 work groups comprised of local public health experts to address topics of pressing interest to local public health agencies. It also sponsors an annual statewide conference for state and local public health professionals. The Commissioner of Health, in consultation with SCHSAC and the MCH Advisory Task Force, is directed by MN Statutes 145A.12, subdivision 7(e), to develop a set of statewide public health measures for the local public health system every five years. These statewide local public health objectives are to be based on state and local assessment data regarding the health of Minnesota residents, the essential local public health activities and Minnesota public health goals. The last set of such measures was developed in 2004. A Statewide Local Public Health Objectives Work Group is being convened and the charge of the work group will be to identify and recommend a new set of statewide local public health objectives to meet the state requirements of the Local Public Health Act funding.

5. The Rural Health Advisory Committee was created during the 1992 Legislative session and serves as a statewide forum for rural health concerns and features a diverse membership consisting of legislators, rural providers, and consumers. Its purpose is to advise the Commissioner and other state agencies on rural health issues and rural health planning. It also carries out its responsibilities through work groups.

6. Title V/Title XIX: The senior program managers for the Title V and the Title XIX programs meet to discuss maternal and child health issues and proposed changes in their respective programs and concerns due to changes in federal and/or state policy. The Title XIX agency is also the designated Title XXI agency. Coordination efforts are laid out in a signed Interagency Agreement.

7. The Management team of the Division of Community and Family Health meets weekly to resolve immediate operational issues and to discuss and define long-range issues. The Management Team of the Division of Community and Family Health is comprised of Division management, (Division Director and Assistant Director), the five Section Managers (MCH, MCSHN, WIC, Health Care Home and the Office of Public Health Practice), and their respective supervisory staff.

B. Agency Capacity

Protecting, maintaining and improving the health of all Minnesotans is the mission of the Minnesota Department of Health (MDH). The Community and Family Health (CFH) Division works to support this mission by providing collaborative public health leadership that supports and strengthens systems to ensure that families and communities are healthy. This is done by partnering to: ensure a coordinated state and local public health infrastructure; improve the health of mothers, children and families; promote access to quality health care for vulnerable and underserved populations; and provide financial support, technical assistance, accurate information and coordination to strengthen community-based systems.

The vision for the public health system in Minnesota is of a strong and dynamic partnership of governments, fully equipped to address the changing needs of the public's health. Minnesota Statutes Section 144.05 gives authority to the Commissioner of Health to develop and maintain an organized statewide system of programs and services to protect, maintain and improve the health of Minnesotans. This includes authority to collect data, prevent disease and disability, establish and enforce health standards, train health professionals, coordinate local, state and federal programs, assess and evaluate the effectiveness and efficiency of health service systems and public health programs in the state, and advise the governor and legislature on matters relating to the public's health. The department carries out its mission in close partnership with local public health departments, tribal governments, the federal government, foreign countries, and many health-related organizations. The MDH workforce of approximately 1,300 includes many MD's, PhD's, nurses, health educators, biologists, chemists, epidemiologists and engineers. MDH budget is approximately $580,000,000 million a year and approximately 85 percent of its funding is from non-general fund resources -- the federal government, dedicated fees, the healthcare access fund, and other revenues. Approximately 62 percent of the budget is "passed through" to local governments, nonprofit organizations, community hospitals, and teaching institutions in the form of grants; 21 percent represents the cost of professional and technical staff that carry out the department's core functions; and 17 percent is for other operating costs, primarily for technology and space.

The language within Minnesota Statutes Chapter 145 lays out the state requirements for the distribution of the federal Maternal and Child Health block grant, with two thirds to go out to local Community Health Boards (local public health agencies) through a formula; establishes the MCH Advisory Task Force; and articulates program requirements for use of state funds for family planning, abstinence education, fetal alcohol syndrome, Women's Right to Know, Positive Alternatives Program, Maternal Death Studies and home visiting. Minnesota statutes articulates that a third of the block grant money retained by the Commissioner of Health may be used to: 1) meet federal maternal and child block grant requirements of a statewide needs assessment every five years and prepare the annual federal block grant application and report; 2) collect and disseminate statewide data on the health status of mothers and children within one year of the end of the year [sic]; (3) provide technical assistance to community health boards in meeting statewide outcomes; (4) evaluate the impact of maternal and child health activities on the health status of mothers and children; (5) provide services to children under age 16 receiving benefits under Title XVI of the Social Security Act; and (6) perform other maternal and child health activities as listed in federal code for the MCH block grant and as deemed necessary by the commissioner.

The delivery of primary and preventive public health services by local government in Minnesota occurs within a framework governed by "Community Health Boards (CHB)." The Boards themselves are comprised of elected officials, either county commissioners or city council members. The Boards provide policy formulation and oversight of the local public health administrative agencies which are responsible for conducting public health core functions. There are 53 CHBs in the state including 27 single-county boards, 59 counties cooperating in 21 multi-county boards, four cities, and one city-county board. This infrastructure provides for a community-based decision-making process based on a needs assessment with state leadership and support. The process recognizes differences among communities and provides a flexible range of responses. Core funding is provided through the Local Public Health Act (a total of $31 million including $6.1 million of Title V funds). Total CHB expenditures for public health activities in 2009, was $298 million, of which 64 percent came from locally generated funds.

CROSS-CUTTING TITLE V PROGRAM CAPACITY

The MCH Advisory Task Force The Maternal and Child Health (MCH) Advisory Task Force was created by the Minnesota Legislature in 1982 to advise the Commissioner of Health on the health status and health care services needs of Minnesota's mothers and children, and the distribution and use of federal and state funds for MCH services. Fifteen members are appointed by the Commissioner with five each representing MCH professionals, MCH consumers, and Community Health Boards. Terms are four years, half coterminous with the governor's term and half one year later. Work groups of the Task Force are often convened with a specific charge to bring back to the full Task Force recommendations made following more in-depth research and discussion. The Task Force just finished its work related to the 2010 MCH Needs Assessment.

The Data Epidemiology Unit: The Data Epidemiology Unit provides data collection, management and statistical analysis, surveillance, consultation, and information dissemination for needs assessment, program evaluation, and decision support to program staff, managers and decision-makers. Epidemiological analyses are conducted in collaboration with established partnerships and data sources, including vital records, Medicaid, hospital discharge data, and national data sources such as the National Children's Survey. The unit includes eight epidemiology staff that provide broad epidemiology expertise, guidance and support to the Title V staff. More targeted support includes such areas as: PRAMS, Newborn and Child Follow-Up for newborn hearing screening, Family Home Visiting, Autism Spectrum Disorder, and the Birth Defects Information System.

In addition the unit provides coordination for the Interoperable Child Health Information System project a cross departmental project working to enhance capacity for interoperability between child health data systems at MDH. Since 2005, Title V and Title XIX have had in place an Interagency Agreement whereby Title V agreed to cover the salaries of one FTE epidemiologists at the Department of Human Services to be able to access Medicaid data for MCH issues.

Tribal Governments: There are 11 federally recognized tribal governments within Minnesota. The Community and Family Health Division coordinates it's key work with the tribes through the Office of Minority and Multi-Cultural Health (OMMH) another Division within the Community and Family Health Promotion Bureau. Legislative action in 2003 acknowledged the role Tribal Governments play in the health status of their communities by including them in the Local Public Health Grant. In response to the significant disparities in infant mortality, childhood obesity, teen suicides and teen pregnancies, tribes were directed to use half of the state general revenue money in this grant for maternal and child issues. Community and Family Health staff work closely with the Tribal Health Liaison in OMMH to provide technical assistance and support to the Tribal health staff and programs for all three MCH population groups.

In addition to specific program areas listed below, Title V staff and programs work to leverage capacity by partnering with related programs situated in other Divisions within MDH. These include lead screening and abatement, laboratory newborn screening, immunizations, STI and

HIV programs, breast and cervical cancer control, asthma, several health promotion program areas, and children's environmental health.

POPULATION CAPACITY: PREGNANT WOMEN, MOTHERS AND INFANTS
Maternal and Child Health (MCH) Section: The MCH Section provides statewide leadership and public health information essential for promoting, improving or maintaining the health and well-being of women, children and families throughout Minnesota. The programs within the MCH Section (described below) strive to improve the health status of children and youth, women and their families. The MCH Section provides administrative and program assistance to local health departments, tribal governments, schools, voluntary organizations, and private health care providers. In addition, MCH programs are involved in a number of collaborative activities to strengthen and enhance partnerships. The overall role of the MCH Section within Minnesota's health care delivery environment is to: assess the health needs of mothers, children, and their families; use that information to advocate effectively on their behalf in the development of policies concerning organizational and operational issues of health systems; and advocate for programs and funding streams which have the potential to improve their health. In addition, the MCH Section has focused on quality assurance of public sector health services, assurance of targeted outreach and service coordination for hard-to-reach and high-risk populations, and community health promotion.

Family Home Visiting: The 2007 legislature amended the Family Home Visiting statute originally passed in 2001 (Minnesota Statutes 145A.17) and increased Temporary Assistance for Needy Families (TANF) funding to local health departments and tribal governments to support the services provided under the statute. The goal of Minnesota's Family Home Visiting Program is to foster healthy beginnings, improve pregnancy outcomes, promote school readiness, prevent child abuse and neglect, reduce juvenile delinquency, promote positive parenting and resiliency in children, and promote family health and economic self-sufficiency for children and families. Home visiting staff provide technical assistance and support to local health departments and tribal governments regarding maternal child health and home visiting program planning, implementation and evaluation. This work is done in close collaboration with local partners (local health departments, tribal governments), MDH programs (C&TC, the Office of Minority and Multicultural Health, injury prevention, MCYSHN), multiple committees, and other state organizations including the Minnesota Association of Infant and Early Childhood Mental Health, Prevent Child Abuse-Minnesota, the National Alliance for Mental Illness-Minnesota, and the Minnesota Sudden Infant Death Center. Much of the work is guided by the Family Home Visiting Steering Committee, the Family Home Visiting Evaluation Work Group, and the Family Home Visiting Training Work Group.

Infant Mortality Reduction: The infant mortality reduction initiative provides resources, education, and technical assistance to local health departments, tribal governments, and community agencies to improve birth outcomes and reduce infant mortality with a particular focus on reducing racial and ethnic disparities in infant mortality and other poor birth outcomes. MDH also supports work to improve the health disparities around infant mortality that exists in the tribal communities in Minnesota. Partners in the program include the Office of Minority and Multicultural Health, the American Indian Community Action Team, the March of Dimes, the Department of Human Services, Twin Cities Healthy Start, Minnesota SID Center, Tribal nursing directors, urban American Indian programs, local health departments, and ACOG Minnesota.

Other infant health programs include the Minnesota's Safe and Asleep in a Crib of Their Own campaign and MDH technical support of the Minnesota legislation to reduce the incidence of abusive head trauma to infants (Shaken Baby Syndrome). This legislation requires birthing hospitals to educate parents of newborns on definitions and prevention strategies before the baby leaves the hospital. MDH staff developed materials and identified videos required for birthing hospitals to educate parents of newborns on the dangers of shaking an infant or young child.

Women's Health: An evaluation of women's health issues and need for coordination is in

progress. It is expected that a new position for women's health will be created within the MCH Section. Current, Title V staff address multiple women's health issues, including preconception health. MDH hosts an annual preconception health conference to collaboratively increase awareness of preconception and interconception health issues. The fourth annual preconception conference is scheduled for October 2010. Topics for a three session webinar series are: 1) impacts of institutional racism, 2) the impact social determinants and health, and 3) the impact of obesity on pre- and interconception health.

Substance Abuse: MDH provides support and technical assistance in the area of substance use (including tobacco and alcohol) during pregnancy to local health departments and providers including screening and assessment of at-risk pregnant women during home visits. To support home visitor's knowledge and skills, MDH provides training on both chemical dependency and motivational interviewing.

Maternal Depression: Postpartum depression education legislation, passed in 2005, requires that hospitals, physicians and other professionals providing prenatal care and/or delivery services provide new parents and other family members written information about postpartum depression. Materials continue to be available for download on the MDH web site. These materials are available in multiple languages including Spanish, Hmong, Somali and Russian. The materials include information about postpartum depression as required by the legislation. The MDH provides technical assistance and review of materials developed by hospitals and other health care providers to assure all such materials comply with the educational requirements specified in the legislation.

Family Planning: The Family Planning Special Projects Grant Program provides over $5 million annually to nonprofit agencies, local health departments, and other governmental agencies to provide family planning services to women and men who have barriers to accessing these services such as poverty, lack of insurance, race, age or culture. MDH staff provides consultation, technical assistance and support for implementation of best practices. This work is done in close collaboration with the MDH HIV/STD staff, the family planning grantees, the MDH Office of Minority and Multicultural Health and the Department of Human Services. State funds also support a family planning and sexually transmitted infection (STI) hotline staffed by individuals trained in information, referral, family planning, and STI counseling. Information on the hotline is mailed annually to Medicaid and Minnesota Care recipients.

The Minnesota 1115 Waiver program, Minnesota Family Planning Program, is an expansion of access to family planning services through Medicaid. The waiver allows the state to operate outside of the normal Medicaid requirements -- it is an expansion of an already existing program that allows people who would not ordinarily meet criteria for services to access family planning services only. All Minnesota residents between the ages of 15 and 50 who have incomes at or below 200% of federal poverty guidelines are eligible.

Positive Alternatives: The Positive Alternatives Program provides approximately $2.4 million annually to support services to pregnant women and women parenting infants that promote healthy pregnancies and assist them in developing and maintaining family stability and self-sufficiency. Currently, 31 grantees offer women information on medical care, nutritional services, housing assistance, adoption services, education and employment assistance, including services that support the continuation and completion of high school, child care assistance, and parenting education and support services.

POPULATION CAPACITY: CHILDREN AND ADOLESCENTS
Child and Teen Check-Ups (C&TC): C&TC is EPSDT in Minnesota. Under a contract with the Department of Human Services, MDH provides technical assistance, consultation, education and training for public and private providers of the C&TC program. C&TC is administered by the Department of Human Services. C&TC (EPSDT in Minnesota) is the well child exam program for children birth to 21 years who are eligible for Medicaid. Staff also recommend best practice well

child screening recommendations to the Department of Human Services C&TC program. Minnesota Early Head Start and Head Start programs, administered by the Department of Education, also follow the federal EPSDT/C&TC guidelines and training. Partners in C&TC include local public health agencies and tribal governments, Migrant Head Start Programs and other Head Start/Early Head Start programs and the Minnesota Chapter of the Academy of Pediatrics.

Child and Adolescent Health Screening: MDH provides technical assistance, consultation, education/training to those who perform early childhood screenings (ECS) and to the Minnesota Department of Education, Early Learning Services. ECS is the mandated preschool screening program administered by the Department of Education. MDH staff train on several of the required and optional components of ECS such as vision, oral/dental health, hearing, developmental and socio-emotional screening as well as physical growth (weight, height), immunization review and health history.

Adolescent Health Activities: The MDH adolescent health coordinator provides leadership and support to promote healthy youth development and help meet the health needs of adolescents statewide. This work is done in partnership with the Departments of Education, Human Services and Public Safety and the MOAPPP. Primary activities include consultation, data analysis, capacity-building and support for best practices in adolescent health at the state and local levels.

School Health/Child Care: MDH has a school health consultant. This position provides education, consultation, and technical assistance throughout the state to school nurses, school administrators, school boards, teachers, parents, early childhood and child care. In addition to working with numerous MDH staff, the school health consultant partners with the Departments of Education and Human Services and the Minnesota Board of Nursing to share program information and enhance school health activities.

Minnesota Early Childhood Comprehensive System (MECCS): The purpose of MECCS is to build and implement statewide early childhood comprehensive systems that support families and communities in their development of children that are healthy and ready to learn at school entry. These systems should be multi-agency and comprising the key public and private agencies that provide services and resources to support families and communities in providing for the healthy physical, social, and emotional development of all young children. The overall goal of the MECCS program is to coordinate early childhood systems for children from birth to five years of age.

POPULATION CAPACITY: CHILDREN WITH SPECIAL HEALTH NEEDS
Newborn Screening and Long-Term Follow Up: Staff partner with the MDH Public Health Laboratories, the MDH Newborn Screening Advisory Committee and the MDH Newborn Hearing Screening Advisory Committee on systems development, data and tracking linkages, and providing education, outreach, technical assistance, and materials development. MCYSHN follow-up staff facilitate enhanced care coordination and services for infants with confirmed conditions found by newborn bloodspot screening or hearing screening. The MDH supports hospitals' provision of newborn hearing screening and tracks hearing results through integration with the state's Newborn Bloodspot Screening database. The department is also developing integration with vital statistics via a web-based system. Staff provides technical assistance to hospitals, early intervention and follow-up, provider training, public information and enhancement of a statewide family-to-family support network. Program activities are coordinated with Part C-MDH staff, faculty for the University of Minnesota Department of Otolaryngology and members of the Newborn Hearing Screening Advisory Committee. The department partners with the Departments of Human Services and Education to provide state leadership in early hearing detection and intervention, including tracking and reporting of outcomes. Sixteen regional teams continue to build capacity in their regions to better serve deaf or hard of hearing children and their families. The 2007 legislative session mandated newborn hearing screening and established a Newborn Hearing Screening Advisory Committee to assist in developing the mandated program. The MCYSHN and the Laboratory jointly support this advisory committee. The 2009 Legislature

provided additional funding to provide support and assistance to families with children who are deaf or have a hearing loss. The family support must include direct parent-to-parent assistance and information on communication, educational and medical options.

Community Systems and Development Team: This team has staff located in District Offices throughout the state. It provides a wide variety of activities at the local, regional, and state levels with public and private agencies and families, including information and referral, child find and outreach, education and training, advocacy, technical consultation, and program/policy development. Members of this team also provide technical consultation to the Health Care Home Section and its efforts to assist primary care practices throughout the state become certified as a health care home. This team works closely with Children's Mental Health Services at the Department of Human Services on children and youth mental health services and needs. The team also provides grant management expertise for the department's suicide prevention grantees and technical assistance and promotion of mental health prevention initiatives. It also contracts with Gillette Children's Hospital for the provision of habilitaive services throughout the state.

Interagency Systems Development: In addition to the Part C interagency activities, staff participate in the state mandated Minnesota System of Interagency Coordination to support the development and implementation of a coordinated, multidisciplinary, interagency intervention services system for children ages birth through 21 with disabilities. This model, based on Part C, requires the development of an Individual Interagency Intervention Plan for all qualifying children, youth and young adults. Significant interagency planning and negotiating has been required between the Departments of Health, Human Services, Education, and Economic Security to support this multi-agency activity. The interagency effort began a focus on transition of 18-21 year olds and will concentrate on that age group in the next few years.

Follow-Along Program: MDH provides technical assistance and training to local public health agencies to support the Follow-Along Program. This program provides periodic monitoring and assessment of infants and toddlers at risk for health and developmental problems and to ensure early identification, assistance and services. This program uses the Ages and Stages Questionnaire as the screening tool and its social emotional component - the ASQ/SE. Special trainings on this tool for its use with the Somali population as well as screening of children in the child welfare system have been targeted toward the Minnesota Department of Human Services and local social services agencies. The ASQ and ASQ-SE continue to be adopted by local agencies. It is the screening tool of choice for the Children's Mental Health Services' ABCD-III grant initiative and has been added to the Child and Teen Checkup (EPSDT) program's trainings.

Research and Policy Analysis: The Research/Analysis and Policy work supports the development and enhancement of capacity to collect and analyze data for research and policy issues around children with special health needs and their families. It has engaged in a number of interagency collaborative activities to assess, direct and influence policy decisions that positively impact children with special health needs. Factsheets on each of the 44 conditions followed by the birth defects information system have been developed. This unit and staff from the Data Epidemiology Unit provide leadership on several internal and external initiatives on autism, including a report on the administrative prevalence of Somali children in Minneapolis special education programs and a one day community forum for Somali parents, health provides and educators.

Quality Improvement: Minnesota adopted the medical home learning model promoted by the National Initiative for Children's Health Care Quality in its national medical home collaborative. Staff worked closely with the state chapter of the AAP, the state Medicaid Agency, Children's Mental Health Services, the University of Minnesota School of Nursing and School of Public Health, Family Voices and parents to develop and promote the medical home concept for all children. This initiative began in 2003, was continued as a grantee under the Bureau's Integrated Systems Initiative (2004-06), received a one million dollar appropriation from the state legislature for 2007-08 and played a significant role in 2008 health care reform legislation. Minnesota participated in the second National Medical Home Learning Collaborative conducted by NICHQ.

These activities have resulted in a core expertise on Family-Centered care, partnerships, coordinated care and learning collaboratives that the MCYSHN program uses throughout all of its program efforts. As part of its EHDI loss to follow-up, it is using the learning collaborative model to reduce the number of infants who fail to be referred to early intervention. It used the model in a just completed one-year community partnership on autism and developmental disabilities and is proposing use of the model in a recently submitted grant to the MCH Bureau on autism and developmental disabilities. Staff also participated in the formation of, and in the on-going operations of, the Minnesota Child Health Improvement Partnership or MN-CHIP. Its mission is to assure optimal family-centered pediatric healthcare through a public-private partnership that supports continuous quality improvement in clinical practices

The Birth Defects Information System (BDIS) is used to provide follow-up to families of all children confirmed with a birth defect. Health information related to the infant's condition is provided and the family is referred to appropriated programs and services.

MCYSHN staff provide frequent trainings to families and providers about various public program services and how to access them through their "Taking the Maze Out of Funding" sessions. These trainings provide updated information to numerous families, agencies and providers throughout the state regarding program and policy changes. The Information and Assistance line provides information about and assistance in finding and accessing services and supports for children with special health needs and their families. Additionally, the web-based Central Directory of Early Childhood Services provides information about services and programs in both the web and hard copy format.

C. Organizational Structure

The Minnesota Department of Health (MDH) is one of the major administrative agencies of state government. The Commissioner of Health is appointed by the governor with confirmation by the state senate, and serves at the pleasure of the governor. State law imposes upon the Commissioner the broad responsibility for the development and maintenance of an organized system of programs and services for protecting, maintaining, and improving the health of the citizens of Minnesota.

The Executive Office is organized into four Bureaus: Policy Quality and Compliance Bureau, Health Protection Bureau, Community and Family Health Promotion Bureau and Administrative Services. Within the Community and Family Health Promotion Bureau are four Divisions, Health Promotion and Chronic Disease; the Office of Minority and Multicultural Health; Office of

Statewide Health Improvement Initiatives and Community and Family Health. The Community and Family Health Division (CFH) is responsible for the administration of programs carried out by allotments under Title V.

The CFH Division is organized into the Director's Office and five sections: Office of Public Health Practice (OPHP), Supplemental Nutrition Program (WIC), Health Care Homes, Maternal and Child Health Section (MCH), and Minnesota Children and Youth with Special Health Needs Section (MCYSHN). The last two sections house the staff and resources where the primary Title V activities take place, although Title V staff work across the whole CFH Division -- as well as across the department.

The CFH Director's office provides overall management of the sections and houses staff who provide shared services to the Division. This includes the Epidemiology and Data Unit, the Communications Unit, and grant and financial management staff. The Director's Office houses 21 staff, seven of which are at least partially funded by federal Title V funds.

The mission of the MCH Section is to provide statewide leadership and public health information essential for promoting, improving or maintaining the health and well-being of women, children and families throughout Minnesota. The structure to support this work consists of three work units: Child and Adolescent Health Unit, Family Home Visiting Unit and the Women's Health Unit. This Section has a total of 24 staff of which six FTEs are funded by federal Title V funds; eight FTEs funded by targeted state funds; approximately ten FTEs funded by various federal grant programs; and other positions funded through a mix of sources for a current total of 32.3 FTEs.

The Minnesota Children and Youth with Special Health Needs (MCYSHN) Section is the Title V CYSHCN program. As such, it seeks to improve the quality of life for children with special health needs and their families through the promotion of the optimal health, well being, respect and dignity of children and youth with special health needs and their families. MCSHN provides statewide support to achieve early identification, diagnosis and treatment, family centered services and systems of care, access to health care and related services, community outreach and networking, and collection and dissemination of information and data. MCSHN is structured into the Research and Policy Unit, the Newborn Follow-up Unit and the Community and Systems Development Unit, which has five staff housed in District Offices across Minnesota. MCSHN has thirteen FTEs funded by the federal Title V funds, two FTEs funded through interagency agreements with the Department of Education, one and a half FTEs funded by federal grants, and approximately eight and a half state funded FTEs for a total of 25 FTEs.

Also within the Community and Family Health Division are the WIC, Health Care Home and Office of Public Health Practice sections. Title V staff work with all of these sections on many shared goals for improved pregnancy outcomes and healthy infants, children and families.

Special Supplemental Nutrition Program for Women, Infants and Children (WIC)
Clearly aligned with Title V program activities, WIC provides over 138,000 women, infants and young children with nutritional foods each month. This program, with a budget of $131,000,000, was designed to improve the health and nutritional status of the eligible populations through the provision of healthy foods, nutrition education and health care referrals. This section distributes federal funds from the United States Department of Agriculture to local Community Health Boards, Community Action Programs, and Tribal governments to administer the WIC program.
Health Care Homes This section is responsible for implementing the health care home component of the ground-breaking health reform legislation passed in May 2008. This legislation included payment to primary care providers for partnering with patients and families to provide coordination of care. Building on the earlier work initiated by the Minnesota Children and Youth with Special Health Needs (Title V program) on medical homes for children and youth with special health care needs, this effort also includes adults with chronic health conditions or disabilities. This section partners closely with the Minnesota Department of Human Services in developing standards for health care homes, the certification process and payment methodology for primary

care providers. Ultimately the goal is to improve health outcomes and quality of life for individuals with chronic health conditions and disabilities.
Office of Public Health Practice The Office of Public Health Practice provides coordination and support to the local public health system which works in tandem with MDH to fulfill public health responsibilities. This interlocking system of state and local effort is critical to mounting an effective response to public health threats. Minnesota has delineated a set of essential local public health activities that characterize local roles for carrying out disease prevention, public health emergency preparedness, environmental health, health promotion, maternal and child health, and connecting people to needed health services. They do this work by partnering with local elected officials, Community Health Boards and local public health administrators and directors to ensure a strong state and local governmental public health system in Minnesota.

As required, organizational charts are available on file in the Director's Office in the Community and Family Health Division.

An attachment is included in this section.

D. Other MCH Capacity

See previous Section C Organizational Structure for the location and numbers of Title V staff.

SENIOR MANAGEMENT BIOGRAPHICAL SKETCHES
The Director of the Community and Family Health Division, Maggie Diebel, has served in that capacity since February 2007. She has extensive experience working in public health, both in service provision and in managing public health programs. She is a registered nurse and has as BA in Human Services Administration from Metropolitan State University in St. Paul, and an MPH from Johns Hopkins University Bloomberg School of Public Health in Baltimore, Maryland. She has clinical nursing experience both at the University of Minnesota and Johns Hopkins hospitals, and served as a nursing advisor in the Cambodian refugee camps along the Thai-Cambodian border. As a Senior Public Health nurse in Arlington County, Virginia, she managed public health support to the county's homeless population, and in 1998, she became the Director of the Office of Population, Health, and Nutrition (PHN) for the United States Agency for International Development in Nairobi, Kenya, having previously managed a regional project operating in east, central, and southern Africa. More recently, she served as Vice President, Program Support Department of Family Health International in Arlington, Virginia where she had oversight of international HIV/AIDS prevention, treatment, care and support programs in over 50 countries.

John Hurley is the state CYSHCN Director and the MCYSHN Section Manager. He has held this position since the fall of 2000. He has a Master's degree in Hospital and Health Care Administration from the University of Minnesota, is a Bush Fellow and pursued further graduate education at the Kennedy School of Government, Harvard University through that fellowship. Prior to becoming the state's Title V-CYSHCN Director, he spent nine years with the Maternal and Child Health section of the state's Title V program specializing in child health issues. Previous to his experience with the state's Title V program, he worked for 18 years in regional health systems planning and hospital corporate activities. He is a member of AMCHP's Legislative and Health Care Finance Committee, a Board member of Minnesota's System of Interagency Coordination, a member of the advisory board for the University of Minnesota School of Nursing's Center for CSHCN and an ex-officio board member for the State Council on Disability

The state MCH Director is the MCH Section Manager. Laurel Briske is the current Director and assumed the responsibilities in August of 2008. Laurel has been at the Minnesota Department of Health nearly 19 years where she served most recently as the public health nursing director in the Office of Public Health Practice. There she managed a technical support and training program for public health nurses and local public health departments. She has also worked in the area of

injury and violence prevention, children with special health needs, and child health screening. Laurel has a master's degree in nursing and is a pediatric nurse practitioner with 30 years of experience in public health programs. Prior to coming to the state health department, Laurel worked as a Head Start health consultant for the U.S. Public Health Service, in a primary care clinic for homeless women and children, as a public health nurse in county public health departments and as a school nurse.

Parent roles. In FFY 2000 the MCYSHN program formed a Family Consultant Advisory Group. The advisory group consisted of up to eight parents that provided parent perspectives on policy issues affecting CSHCN. Parents who had demonstrated significant leadership and advocacy skills in service system or policy development at the state or local level were asked to serve. Most were graduates of Parents in Policymaking (a program of the Governor's Council on Developmental Disabilities) or the Minnesota Early learning Design (MELD) Special Parent trainings. The group was formed to advise the MCYSHN program on its efforts to integrate the MCHB's six core outcomes, review and comment on work plans and to focus on disparities between CYSHCN and their non-special need peers.

The group was staffed on a volunteer basis by a staff member of a local, non-profit, parent-education advocacy organization. She left that organization in 2005 to assume the staff role in MCYSHN's medical home activities and this advisory group dissolved. One of the operational tenets of MCYSHN's medical home activity was the presence of at least two parents on each medical home team, as well as the use of parents and parent resources as faculty for the learning sessions in the medical home collaborative. Between 2005 and 2010, MCYSHN conducted three separate quality improvement initiatives using the IHI Breakthrough Model and the structure of collaborative learning sessions. These initiatives were focused on medical home, early hearing detection and intervention loss to follow-up and autism/developmental disabilities community partnerships. Teams were formed in each of these initiatives and a condition for team participation was parent representation/membership on each team. In addition, colleagues at the Minnesota Department of Human Services (the state's Medicaid Agency), because of their participation in medical home activities have adopted the structure of this quality improvement approach, including the presence of parents on teams. Both the EPSDT program and the Children's Mental Health Services (CMHS) program have used it. Examples being the DHS participation in the ABCD-II grant program sponsored by The Commonwealth Fund and its current participation in the ABCD-III grant program. Finally, Minnesota is one of the states participating in state improvement partnerships modeled after the Vermont Children's Health Improvement Partnership. The Title V program was instrumental in the formation of the Minnesota effort and the inclusion and recruitment of parents on the advisory board of the Minnesota Child Health Improvement Partnership (MN-CHIP).

The MCH Advisory Task Force is a legislatively mandated committee that provides the Commissioner of Health recommendations on the health and well-being of Minnesota's women and children. It is a fifteen member committee made up of five each of MCH professionals, local public health representatives and consumers. The five current consumers are:

Carol Grady: Carol was appointed to the task force in 2005. She was a journalist who pursued a career in nursing following the birth of her special needs son (who passed away in 2007). Carol has become an advocate for parents and works to bridge the gap of understanding between MCH professionals and parents. In 2009, Carol served as Minnesota's AMCHP family delegate and AMCHP family scholar. In 2010, Carol served again as one of Minnesota's AMCHP family delegates. Carol currently works as a school nurse and in the NICU of a children's hospital.

John Hoffman: John was appointed to the task force in 2007. John also serves on the executive committee of the task force. John's daughter was diagnosed with spina bifida at 24 weeks gestation. John's experience with the medical system and his daughter's eventual connection to a medical home led him to advocacy work for children with special needs. In 2009 John was an AMCHP family delegate and was also selected as an AMCHP family mentor. John works as

Marketing and Public Relations Director for an organization that finds employment opportunities for adults with disabilities.

Allison Senogles: Allison was appointed to the task force in 2007. Allison is Native American and has been a foster mother to special needs children; many of whom she has adopted. During her tenure with the task force, Allison has pursued a career in nursing. She recently moved her family to northern Minnesota to be closer to her family and her work at the Red Lake Indian Reservation hospital.

Wenqing Han: Wenqing was appointed to the task force in 2008. She is a Chinese native (U.S. Permanent Resident) living in the U.S. for 12 years. She has been a volunteer for the Chinese Clinic in St. Paul for four years. She is a nurse by training and worked as a general surgery nurse in China.

Coral Garner: Coral was appointed to the task force in 2004. Coral also serves on the executive committee for the task force. Coral, an African American, is the director of Community and Public Health Initiatives for the City of Minneapolis Department of Health and Family Support. Ms. Garner was also the director of Twin Cities Healthy Start, which provides maternal and child health outreach, case management, and education to American Indian and African American women in the metro area.

Several CYSHCN staff are also parents with one or more children who have a special health care need. The roles these parents perform and the positions they occupy in the program include supervisory, policy and program planning, and technical consultation for statewide programs.

E. State Agency Coordination

Collaboration and coordination is a fundamental value and strategy for the work of Title V. It is essential to the accomplishment of our goals. Many of the earlier sections of this report as well as the Performance Measure narratives describe multiple partnerships between Title V, other MDH program areas, other state agencies, community-based entities, and local public health. These relationships are both long-standing, and also include some exciting new opportunities. Some of these are formal with Interagency Agreements and MOUs in place, and many are less formal.

INTRA-AGENCY COORDINATION

Office of Rural Health and Primary Care Minnesota's Title V and Primary Care Office (PCO) programs support each other's mission and the goals and objectives of their respective SSDI and Cooperative Agreement (CA) grants. The mission of the PCO is to improve access to preventive and primary care services for underserved Minnesotans. The Title V program works, in part, to further efforts of organizations that deliver health services to mothers and children and to provide leadership for statewide maternal and child health issues. Both programs promote the development of community-based, family-centered, comprehensive, coordinated, and culturally competent systems of services as a priority. Annually, the Office of Rural Health and Primary Care, the Minnesota Rural Health Association and the Rural Health Resource Center host a Rural Health Conference that brings hospital and clinic administrators, EMS, rural public health agencies as well as others together to discuss pressing issues. It is an opportunity for Title V programs to present new information and hear from our partners the issues facing mothers and children in outstate Minnesota.

The Office of Minority and Multi-Cultural Health (OMMH) relies on Title V staff for specific program area expertise for the Eliminating Health Disparities grantees, and Title V staff likewise rely on OMMH staff for access, guidance and assistance in their work with ethnic/cultural activities and groups. These partnerships have produced several joint trainings, conferences and other projects. Recent joint efforts have focused on an American Indian Infant Mortality Review

project. This activity examined American Indian infant deaths (within the first year of life) that occurred in 2005 and 2006. Information for case summaries was obtained from birth and death records, health records, autopsy reports as well as interviews with mothers. Qualitative and quantitative data were combined to create a comprehensive picture of each infant death which was then reviewed by an expert panel, representing a cross section of professionals and key community representatives. Recommendations from that report have guided community action teams in the American Indian communities to address this issue. Another joint effort is around Family Home Visiting. A staff member from the OMMH responsible for tribal Family Home Visiting programs was transferred to Title V program to assure a coordinated state approach to implementing and evaluating the program between local public health and tribal governments.

Tobacco Prevention and Control Program (TP&C) and Title V MCH Section staff continue to work together to address tobacco prevention among children and families in Minnesota, with a growing focus on smoking cessation for pregnant women. Staff from both sections partner in the Robert Wood Johnson/ ACOG/Planned Parenthood project.

Center for Health Statistics (CHS) The Center for Health Statistics staff work on numerous activities with Title V staff including data analysis, data and systems planning, training and presentations, and consultation. Joint activities underway include matching birth certificate information with newborn screening information, and with the Birth Defects Information System (BDIS). The CHS unit continues to play a key role in providing birth and death data for the block grant. They are currently partnering with the teen pregnancy prevention coordinator analysis birth record data and because of their expertise with large data bases have agreed to coordinate the matching of WIC and birth certificate data.

The Division of Environmental Health houses several program areas with which Title V is a priority partner including the lead program and other environmental programs that affect the health of children.

The State Public Health Laboratory and Title V staff work in tandem on the newborn bloodspot and hearing screening programs in planning, administration, education and training, monitoring, evaluation and follow-up.

Ongoing relationships exist between Title V staff and several other program areas in MDH that enhance the work of both partners and frequently produce special short-term projects or activities. These areas include the immunization program, injury prevention, nutrition (outside of WIC), obesity, sexual violence prevention, STI / HIV prevention and Refugee Health. The autism team is convened and supported by Title V but draws it's members from across the department.

INTER-AGENCY COORDINATION

Department of Human Services (DHS): The Title V programs and the Department of Human Services (the state's designated Title XIX and Title XXI agency) have a long history of collaboration framed by a formal interagency agreement. DHS is represented on the MCH Advisory Task Force in an Ex-Officio status and Title V participates on the Medicaid Advisory Task Force. Numerous other activities are noted throughout this application. Formal contracts exist which provide DHS funding for staff in Title V programs relative to EPSDT, and Title V funds a Epidemiologist at DHS to provide assistance with Medicaid data requests. Management and Executive Office staff of MDH and DHS meet to discuss issues of mutual interest and concern. Minnesota has several early childhood programs administered by DHS (i.e. Child Care) and representatives of these programs were involved in the MECCS grant (Minnesota Early Childhood Comprehensive Statewide Systems) grant. Title V staff are important partners with DHS involved in the ABCD III grant, aimed at strengthening services and systems that support the healthy mental development of young children as well as working in collaboration with the Alcohol and Drug Abuse division on substance abuse and treatment for women, especially pregnant women.

Department of Education The Title V program and the Department of Education (MDE) collaborate on many projects and programs: Children's Mental Health, Part C, Early Childhood Screening, teen pregnancy prevention, home visiting, service coordination (for ages 3-21), a children's advocate group, and a grant advisory board regarding children with special health care needs and child care. There is active collaboration between MDE and MDH on the Minnesota Student Survey.

The MDE is the lead agency in Minnesota for the Early Childhood Intervention Program (Part C), a joint initiative of three state agencies: (Health, Human Services, and Education) and local IEICs (Interagency Early Intervention Committees). Through an interagency agreement, the Department of Health receives funding for specific activities and staff within the CYSHCN program. As part of the Part C activities, Title V staff actively participate on the mandated State Agency Committee (SAC) and the governor appointed Interagency Coordinating Council (ICC). The Department of Health's Part C team provides outreach, information, training, and technical assistance on health related early childhood topics and issues to families; state, regional, and local health, education, and human service agencies; public and private providers and IEICs (Interagency Early Intervention Committees). The MDH team takes the lead for public awareness/child find; ongoing technical support of the Follow Along Program (tracking system for identifying children at-risk); a statewide information and assistance line (central directory requirement); establishing and maintaining an interagency data system; and providing training and technical assistance on managed care issues, health benefits coordination, and outreach to health care providers on Minnesota's early childhood intervention system.

Department of Corrections: The Department of Corrections participates with MDH, DHS, and Minnesota Department of Education on children's mental health issues in the state. This relationship has been long standing and provides avenues to address children's mental health issues in juvenile correction centers. Title V staff also collaborate with the Minnesota Department of Corrections on adolescent health issues through the Interagency Adolescent Female Subcommittee (IAFS). This is a subcommittee of the Department of Correction's Advisory Task Force for Female Offenders in Corrections. The MCH Adolescent Health Coordinator is a member of the IAFS and provides the adolescent health perspective to its work, assuring gender-specific programming for girls in corrections.

Children's Mental Health Collaboratives: The primary focus for children's mental health in Minnesota is the development of a community-based, unified system of services for the child and family. The Comprehensive Children's Mental Health (CCMH) Act requires that counties provide a specified array of mental health services to children. The CCMH Act establishes guidelines for development of Children's Mental Health Collaboratives including integration of funds in order to use existing resources more efficiently, minimize cost shifting and provide incentives for early identification and intervention. This focus on early identification and intervention gives increased importance to public health agency efforts and expands opportunities for coordination with other services. Local partnerships with social services, corrections, and education agencies create integrated systems that improve services to children with mental health problems and provide services for their families.

Family Service Collaboratives: Family services collaboratives were initiated in 1993 by the Minnesota legislature which mandated public health's involvement, recognizing the vital role public health plays in assessing and addressing the health of all mothers and children in communities and the state. Included in this initiative were collaboration grants to foster cooperation and help communities come together to improve results for Minnesota's children and families. By providing incentives for better coordination of services, Minnesota hoped to increase the number and percentage of babies and children who are healthy, children who come to school ready to learn, families able to provide a healthy and stable environment for their children and children who excel in basic academic skills. Recognizing that no single funding source alone is responsible for changing outcomes, a set of statewide core outcomes was distilled from the collaborative efforts. Promoted across systems in 1998, this list has been included in the work of

the Family Support Minnesota, formerly the STATES Initiative, the KIDS Data Project, and Minnesota Healthy Beginnings, among others. Many of these outcomes and their indicators align with the federal/state MCH performance measures and many others offer future directions for development of measurement tools, in particular, those with the promotional perspectives of family support.

Coordinated System for Children with Disabilities Aged Three to 21 -- involving multiple state agencies: State law mandates a coordinated interagency system for children from three to 21 with disabilities, as defined by IDEA. CYSHCN staff have been actively involved with an 18 member State Interagency Committee made up of seven state agencies and other participants for oversight of this planning, as well as numerous workgroups creating the guidance for this system at both the state and community level.

Community Health Boards The Community Health Services (CSB) Act of 1976, and its revisions through the 1987 Local Public Health Act, established a comprehensive local public health system and laid the foundation for the effective state-local public health partnership Minnesota enjoys today. The 1976 CHS Act allowed county and city boards of health to organize as community health boards, provided they met certain population and boundary requirements. By meeting these requirements, counties and cities became eligible to receive a state subsidy. Local boards of health are consolidated into 53 community health boards. Twenty-eight counties function as single-county CHBs, 59 counties cooperate in 21 multi-county or city-county CHBs, and four are city CHBs. Title V programs collaborate closely with all community health boards as they implement MCH programs at the local level. Title V programs provide grant administrative oversight of the Title V funds awarded to CHBs, provide MCH and CYSHCN technical assistance, consultation and share best practices on such topics as evidenced based home visiting, infant mortality, teen pregnancy prevention, and transition, and work to build capacity to meet the needs of mothers and children.

University of Minnesota: Collaboration between the Title V programs and the University of Minnesota School of Public Health continues on various research, evaluation and training projects. The MCH program within the School of Public Health holds an Ex-Officio position on the Maternal and Child Health Advisory Task Force. The Department's Title V program collaborates with the school's MCH program community education activities including presenting at its annual summer Institute. A number of MPH students have their internships in the Division of Community and Family Health, and several Title V program staff are graduates of the program. Faculty from the University have provided training and technical assistance to Title V staff through informal communications as well as some sessions--particularly as part of the building capacity activities underway over the past two years. The MCH Adolescent Health Program collaborates extensively with the University of Minnesota Konopka Institute for Best Practices in Adolescent Health, Division of General Pediatrics and Adolescent Health. This partnership focuses on building the capacity and skill of adolescent-focused programs across the state. MCH Reproductive Health staff collaborate with the National Teen Pregnancy Prevention staff at the University of Minnesota on numerous projects including the implementation of the state teen pregnancy prevention and parenting plan. The CYSHCN program serves as mentors for each of the students in the University of Minnesota School of Nursing program emphasizing CYSHCN. The University of Minnesota receiving status as an Academic Center of Excellence in Women's Health has brought opportunities for enhanced relationship and shared activities. This dual partnership has also extended to include the Community Center of Excellence at an urban Minneapolis clinic. The University recently received a LEND grant from the MCHB. CYSHCN staff assisted in the preparation of the application, participate on its advisory board and collaborate in other ways on topical issues such as autism.

F. Health Systems Capacity Indicators

Introduction
The Health System Capacity Indicators provide useful measures of important MCH issues, and the annual reporting helps us monitor progress and use this information to inform public health practice and policy. The annual collection and review of these indicators creates opportunity for collaborative discussion and work with partner programs here at MDH including the asthma and injury programs. We have a strong working relationship with our state Medicaid agency and fund a joint position at that agency that gives us good access to Medicaid data which helps us identify issues and projects of shared interest.

While Minnesota is a state with relatively generous health care programs and typically does very well in many of these indicators, these overall numbers mask our issue of significant disparities based on race, ethnicity, and other factors. As we drill down further into these indicators and look at them based on race, ethnicity, insurance status, geographic location, and income levels, we find additional issues needing targeted focus and strategies. We are working to build epidemiological and surveillance capacity in our Title V and related program areas at the state level - and also to turn this data into useful information for numerous communities across the state.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	25.9	27.5	31.2	21.4	
Numerator	846	885	1046	746	
Denominator	326227	322047	335694	347835	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
2008 is the most recent data available. We will not have 2009 hospital-based data for rates of children with asthma until early 2011.

Notes - 2008
2008 data not yet available.

Notes - 2007
2007 data not yet available

Narrative:
In any given year, hospitalization for asthma usually shows seasonal fluctuations, peaking in the fall, then declining gradually until spring when a second--and slightly smaller--peak occurs. The annual rate for asthma hospitalization in Minnesota during the years 2004-2007 hovered in the range between 25.9 -- 33.6 hospitalized asthmatic children per 10,000 children less than 5 years old. However in 2008, the source of our most recent data, the rate dropped to 21.4 per 10,000 children under age five.

At this time, we do not have a simple explanation for this decrease. According to the Minnesota

Hospital Association, which gathers and maintains the data, the decrease does not appear to stem from anomalies in the statistical database. Data indicates that while there was a sharp drop in hospitalizations in children, particularly children under age 4, there was not a drop in hospitalizations of adults 35 to 64. Hospitalizations for this age group has remained constant over the past 10 years. The Asthma Program hypothesized that the length and severity of the influenza season in any given year can be responsible for a sharp rise or drop in hospitalizations of asthmatic children as well as the accuracy of spirometry test outcomes is often questionable, as many children under the age of five are unable to successfully complete this test. Another variable lies in the classification of asthma, which is defined in various ways by different hospitals. Meanwhile, MDH continues to look at insurance status, race/ethnicity, geographic location, neighborhood conditions and socio-economic factors in areas with high rates. Any of these factors may influence the onset of asthma as well as the subsequent need for hospitalization.

In 2007 MDH, in conjunction with other colleagues and stakeholders, updated the "Strategic Plan for Addressing Asthma in Minnesota." Since that time we have been providing asthma education to health professionals, developing public policies to reduce exposure to environmental factors which may trigger asthma, and creating increased general awareness of this illness. The goal of this strategic plan is to improve the lives of individuals living with asthma (particularly children), as well as reduce the necessity for hospitalization and/or emergency room use. Perhaps the reduced hospitalization rate in 2008 may have been influenced by this effort.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	87.0	85.1	87.0	86.9	87.1
Numerator	48467	26114	27667	28006	28267
Denominator	55707	30669	31790	32232	32450
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:
This measure has been quite consistent over the past several years, ranging from a low of 85.1% in 2005 to a high of 87.3% (2004) and 87.1% (2009), our most recent data. Title V staff from both MCH and MCYSHCN work closely with the Minnesota Department of Human Services (DHS) to maintain and improve the screening process for young children throughout the state. MDH is currently under contract with DHS to train local providers who then implement the EPSDT program.

Training programs have been developed for public health nurses, school nurses, local county workers and others. Trainings include on-site consultation and followup as well as outreach strategies. Material on the Medicaid application process is also included.

There are two existing collaboratives currently focusing on early childhood screening: (1) Minnesota Early Childhood Comprehensive Screening (MECCS); (2) Family Home Visiting Program (FHV). Both have outcome measures directly related to appropriate, timely and ongoing

screening of young children. In addition, two Outcome Measures incorporated in the Title V Block Grant Program are relevant to this HSCI: (1) Increase the percentage of children ages 0-3 who are screened for developmental and socio-emotional issues every 4-6 months; and (2) Increase the participation rate of Medicaid and MinnesotaCare-enrolled children ages 0-21 who receive Child and Teen Check-ups (Minnesota's EPSDT program).

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	0	0	0	0	0
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
There is no SCHIP program in MN at the present time.

Notes - 2008
MN does not participate in this program.

Notes - 2007
Historically there are less than 100 children enrolled on SCHIP. Eligibility critieria is children under two whose family income is between 275 FPG and 280 FPG.

Narrative:
Not applicable. SCHIP eligibility in Minnesota covers infants 0 to 2 years old whose family income is between 275% and 280% of federal poverty. Thus, there are very few children enrolled making this measure not applicable.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	77.6	77.9	80.3	82.5	
Numerator	54922	57101	59001	59566	
Denominator	70750	73300	73477	72166	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average					

cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2009
2008 is the most recent data which we have for this measure. The 2009 data will not be available until earlyh 2011.

Notes - 2008
2008 natality data not yet available.

Notes - 2007
2007 data not yet available

Narrative:
Data for this measure comes from the Minnesota Center for Health Statistics, which processes annual Vital Statistics data and maintains the state Natality Database. Statistics on this measure have been steadily improving over the years. We have exceeded the 80% goal on the Kotelchuck Index in both 2007 (80.3%) and 2008 (82.5%). Unfortunately, these figures are not consistent across the state or across different populations living in the same geographic area.

Disparities continue to exist between populations of color, American Indians, and Hispanics, who are frequently unable to access prenatal care at the same rate as White women. High uninsurance rates for Hispanic women, in addition to an increasing number of undocumented immigrants and a general distrust of government policies with regard to immigration status, often prevent Latinas from obtaining adequate prenatal care. Black and American Indian populations also have diaparities in adequate prenatal care. Title V staff have been working with the MDH Office of Minority and Multicultural Health, as well as Tribal Governements and the Twin Cities Healthy Start program and local community clinics, to resolve these issues and increase the percentage of racial and ethnic women obtaining early and adequate prenatal care.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	79.3	79.2	77.6	89.0	66.2
Numerator	361695	364416	364189	367309	345850
Denominator	456000	460000	469436	412709	522435
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
2007 data is not yet available

Narrative:
This indicator has seen nearly a 23% drop from 2008 (89.0) to 2009 (66.2) after several years of gradual increases and proactive initiatives on the part of Minnesota Departments of Health and Human Services. The most likely explanation for this divergence can be found in the denominator

used for the 2009 calculations, which is the sum of two components: number of children ages 1 through 20 years enrolled in Medicaid during 2009 and number of children in that same age range who were uninsured in 2009.

Although Medicaid enrollment for children ages 1 through 20 did increase in 2009 (denominator), the number receiving at least one medical service (numerator) did not increase. In fact, the 2009 numerator decreased from 367,309 to 345,850 children in that age range. Continued education and outreach is needed to inform new enrollees about medical and other services available through Medicaid.

The number of children without insurance also rose substantially in 2009, creating a denominator with more than 100,000 additional children than 2008 (412,709 vs. 522,435). Hopefully, the number of uninsured children will decrease as the economy improves. Further, the Health Economics Program at MDH has just completed a new 2009 Health Access Survey, which is in the final stages of data analysis and should produce current, updated figures for next year's numerator and denominator.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	48.5	48.2	48.8	51.1	52.4
Numerator	35728	36160	36814	39448	43468
Denominator	73680	75058	75490	77167	82920
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:
This indicator has been steadily increasing over the past several years, rising from 47.7 in 2004 to 52.4 in 2009. While this trend has been encouraging, it does not even approach the rate of participation by EPSDT-eligible children in Medicaid health services.

There are many challenges in obtaining professional dental services for Medicaid participants. Locating providers who will accept Medicaid reimbursement, is a major obstacle. Further, rural areas have a shortage of dentists. In recent years, dental hygienists have been allowed to assume additional responsibilities. However, it is still very difficult for all EPSDT-eligible children to obtain needed dental preventive and restorative services at a time in their lives when early care is important to establishing a foundation for future dental health and medical wellness.

In 2008 Minnesota was awarded a CDC Oral Health Infrastructure Grant and a HRSA Oral Health Workforce Grant. Activities pertaining to these grants will assist in building the required infrastructure and should improve the oral health of our most vulnerable populations, including children on Medicaid.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	9046	9541	10264	11337	10925
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
MCYSHN does not pay for direct services. Children who are receiving SSI financially qualify for MN Medical Assistance.

Notes - 2007
2007 data not yet available

Narrative:
In Minnesota, Medicaid provides a comprehensive package of services which includes rehabilitation, and nearly all children/youth on SSI are eligible for Medicaid. Therefore, the state CYSHCN program no longer has a role in providing direct service. However, the CYSHCN program does contact families who are eligible for SSI to assure that families know about Medicaid eligibility and any other services that may be available to them.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2008	matching data files	7.7	5.6	6.4

Narrative:
Low birth weight rates have been increasing in Minnesota for both Medicaid and non-Medicaid births. Minnesota also sees substantial disparities within our populations of color, as well as among young mothers (especially teens), and these groups are substantially represented within the Medicaid population. Thus, a higher low birth rate among Medicaid recipients would be expected. Our current initiatives to reduce infant mortality and increase early and adequate prenatal care should also impact birth weight rates.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2007	matching data files	5	4	4.4

Narrative:
In 2007 infant death rates have continued to decrease for both Medicaid and non-Medicaid populations, with the reduction in Medicaid deaths being greater (6.8 in 2006 down to 5.0 in 2007 for Medicaid; 4.1 in 2006 down to 4.0 in 2007 for non-Medicaid). However, the number of deaths are small in number; thus, they must be interpreted cautiously. Noticeable disparities continue to exist between White infant death rates and rates for Black and American Indian populations. Reducing these disparities continue to be a high priority.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2008	matching data files	76	91.6	85.6

Narrative:
Early and adequate prenatal care continues to be substantially less for women on Medicaid when compared to non-Medicaid women. In 2008, 15.6% more non-Medicaid women received early care (91.6%) than Medicaid women (76.0%). These percentages showed no change from 2007 to 2008 for either group. The federal goal established for the Healthy People 2010 objective is 90 percent, and non-Medicaid women have already met and exceeded this goal. Again, this disparity is partly due to the high representation of racial and ethnic populations enrolled on Medicaid.

Education in addition to access and insurance coverage contribute to achieving this objective, in addition to access and insurance issues. Towards this end, MDH is conducting an annual series of educational workshops and web-based seminars designed to inform providers as well as clients/patients about the importance of early and adequate prenatal care, including preconception and inter-conception care.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 *Comparison of health*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-	ALL

system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State				**MEDICAID**	
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2008	matching data files	78.5	85.1	82.5

Narrative:
Adequate prenatal care is an extension of early care, and the Kotelchuck Index is a measure which takes into account both of these factors. It is not possible to have adequate care without also having early prenatal care. Thus, the combined index is more difficult to achieve. On this measure, non-Medicaid women do not perform as well as with early care, although they still achieve a higher score (85.1%) than non-Medicaid women (78.5%). Hopefully, the workshops and web-based educational opportunities sponsored by MDH (and cited in 5C above) will assist both groups of women in removing the barriers necessary to achieving the best pregnancy outcomes.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2009	275
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2009	280

Narrative:
The percent of poverty level for eligibility in Minnesota's Medicaid program is 275% for infants 0 to 1 year of age. SCHIP program eligibility is between 275 -- 280%, resulting in very few infants on SCHIP in Minnesota.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 2) (Age range 2 to 18) (Age range 19 to 20)	2009	 275 150 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**

women.		
Medicaid Children (Age range 1 to 2) (Age range to) (Age range to)	2009	280

Narrative:
There are three populations eligible for SCHIP in Minnesota: (1) infants under age 2 who are at or between 275 -- 280% of poverty; (2) Non-citizen, pregnant women who are not eligible for Medicaid status due to immigration status and who are at or below 275% of poverty; (3) MinnesotaCare (state-sponsored health insurance program) parents who are at or below 100-200% of poverty.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2009	275
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2009	280

Narrative:
Approximately 34% of all births in Minnesota are to women enrolled in Medicaid. SCHIP eligibility only includes pregnant women who are non-citizens and who are not eligible for Medicaid due to immigration status and whose income is at or below 275% of the federal poverty level.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	No
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	No
Annual linkage of birth certificates and WIC eligibility files	2	No
Annual linkage of birth	3	Yes

certificates and newborn screening files		
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2011

Narrative:
The Title V programs have a strong partnership with the Office of Health Statistics (MDH - birth and death) and with the Department of Human Services (Medicaid). A data sharing agreeement with both entities covers the joint work activities that supplies data for the MCH Block Grant application and for joint projects such as the Disparities in Infant Mortality report that was produced in 2009 and the soon to be released Low Birth Rate Report Comparing Medicaid births with non-Medicaid births. This allows the Title V programs to use staff who are most familiar with the data bases to do the actual matches but bring in Title V staff expertise in planning and anaylsis.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	1	No
Minnesota Student Survey	3	No

Notes - 2011

Narrative:
Minnesota does not participate in the CDC Youth Risk Behavior Survey. Minnesota data on youth is obtained through the Minnesota Student Survey which is administered every three years to 6th, 9th, and 12th graders. In response to the question regarding cigarette smoking in the 2007 survey, data indicates a continued downward trend across all three age groups. Although more than one in five 12th graders still reported smoking cigarettes in the past month, these are the lowest rates reported in the history of the Minnesota Student Survey.

IV. Priorities, Performance and Program Activities

A. Background and Overview

This section provides an overview of Minnesota's success and activities in addressing the priorities established through the Title V block grant and as determined by Minnesota's needs assessment process. The state performance measures reported in this section are in the last year of a five year reporting cycle. New state priorities and performance measures have been developed through the 2010 needs assessment process. These new state priorities and measures will be discussed in Section B. The measurement of the new state priorities will begin next year.

At the end of the previous five-year cycle, Minnesota data show that the majority of 2005 State Performance Measures have improved. These include:

SPM 1: Counties offering the Follow-Along Program.
SPM 2: Children receiving C&TC.
SPM 3: Sexually active ninth graders using condoms.
SPM 4: Child maltreatment.
SPM 5: Pregnancies that are intended.
SPM 6: Maternal depression screening during prenatal care.
SPM 7: Enhanced mental health promotion and suicide prevention.
SPM 9: CYSHCN with unmet needs for specific health care services.
SPM 10: CYSHCN receiving mental health screening, evaluation, and treatment.

One state performance measures remained the same:

SPM 8: LBW infants to American Indian women and women of color compared to white women.

As for the National Performance Measures, Minnesota has show improvement (based on the most recent data available) on the following measures:

NPM 1: Newborn bloodspot screening follow-up.
NPM 2: Families partnering in decision making for CYSHCN.
NPM 7: Children receiving age appropriate immunizations
NPM 9: Children receive protective sealants on one molar.
NPM 11: Mothers who breastfeed their infant at 6 months of age.
NPM 12: Newborns screened for hearing before hospital discharge.
NPM 13: Children without health insurance.
NPM 15: Women who smoke during pregnancy.
NPM 16: Suicide deaths among youth.
NPM 17: VLBW births high-risk facilities.

One measure stayed the same; however was slight improvement from year to year.
NPM 10: Motor vehicle deaths of children.

Minnesota did not show improvement on the following NPMs. Again, some of these measures showed either very slight change or sometimes improvement from year to year over the five years.

NPM 4: Adequate public and/or private insurance for CYSHCN.
NPM 8: Births to teenagers.
NPM 14: Children with a BMI at or above the 85th percentile.
NPM 18: Infants born mothers receiving prenatal care beginning in the first trimester.

Three measures for CYSHCN are not comparable between the baseline year ensuing years.

However, it is known that in comparison to other states, Minnesota ranks 44th in the percentage of CYSHCN with a medical home and that a statically significantly larger percentage of YSHCN received adequate transition services.

NPM 3: CYSHCN receiving care in a medical home.
NPM 5: A service system for CYSHCN that is organized and easy to use.
NPM 6: Youth with special health care needs receiving services necessary for transition adulthood.

B. State Priorities

The 2010 needs assessment document (II. Needs Assessment) more fully describes the relationship between the new Minnesota priority needs, the national and state performance measures and the capacity of the state Title V program. Minnesota identified two overarching goals seven priority needs that reflect the comprehensive nature of the Title V block grant and the complexity and inter-relatedness of the target populations. The two overarching goals and seven broad priority needs for Minnesota include:

Overarching Goal 1: Increase health equity and reduce health disparities for pregnant women, mothers and infants, children and adolescents, and children and youth with special health care needs.
Overarching Goal 2: Focus efforts on activities that result in positive outcomes across the lifespan.

Priority Need 1: Improve Birth Outcomes
Priority Need 2: Improve the Health of Children and Adolescents
Priority Need 3: Promote Optimal Mental Health
Priority Need 4: Reduce Child Injury and Death
Priority Need 5: Assure Quality Screening, Identification and Intervention
Priority Need 6: Improve Access to Quality Health Care and Needed Services
Priority Need 7: Assure Healthy Youth Development

A number of items were included in the development of the priorities for the state, including priority issues for the state identified in a stakeholder survey; the national performance measures; the national health outcome measures; the national health status indicators; and the national health system capacity indicators.

Following is a listing of state and national measures and their relationship to Minnesota's goals and priority needs.

Overarching Goals 1 and 2:

HSI 06A&B: MCH populations by race/ethnicity
HSI 07A&B: Live births by maternal age, race and ethnicity
HSI 10: Geographic living area for children
HSI 11: State population at federal poverty level
HSI 12: State MCH populations at federal poverty level

Priority Need 1: Improve Birth Outcomes

NEW SPM 1: Women who did not consume alcohol during pregnancy
NPM 8: Births to teenagers
NPM 15: Women who smoke during pregnancy
NPM 17: VLBW births high-risk facilities
NPM 18: Infants born to mothers receiving prenatal care beginning in the first trimester

HSCI 04: Women with a live birth receiving expected prenatal visits
HSI 01A: Live births less than 2,500 grams
HSI 01B: Live singleton births less than 2,500 grams
HSI 02A: Live births less than 1,500 grams
HSI 02B: Live singleton births less than 1,500 grams
HOM 1: Infant mortality
HOM 2: Black infant mortality compared to the white infant mortality
HOM 3: Neonatal mortality
HOM 4: Post-neonatal mortality
HOM 5: Perinatal mortality plus fetal deaths

Priority Need 2: Improve the Health of Children and Adolescents

REVISED SPM 2: Children receiving recommended C&TC visits
NPM 7: Children receiving age appropriate immunizations
NPM 9: Children receive protective sealants on one molar
NPM 11: Mothers who breastfeed their infant at 6 months of age
NPM 14: Children with a BMI at or above the 85th percentile
HSCI 09B: States ability to monitor tobacco use by children and youth
HSCI 07B: EPSDT eligible children who receive any dental services
HSCI 01: Children hospitalized for asthma
HSI 05A: Women aged 15 through 19 with chlamydia
HSI 05B: Women aged 20 through 44 with chlamydia

Priority Need 3: Promote Optimal Mental Health

NEW SPM 3: Children who receive a mental health screening
NPM 16: Suicide deaths among youth

Priority Need 4: Reduce Child Injury and Death

REVISED SPM 4: Cases of child maltreatment
NPM 10: Motor vehicle deaths of children.
HSI 03B: Death from motor vehicle crashes in children 14 and younger.
HSI 03C: Death from motor vehicle crashes in youth 15 through 24
HSI 04B: Non-fatal injuries from motor vehicle crashes in children 14 and younger
HSI 04C: Non-fatal injuries from motor vehicle crashes in youth 15 through 24
HSI 03A: Death due to unintentional injuries in children 14 and younger
HSI 04A: All non-fatal injuries in children 14 and younger
HSI 08A&B: Deaths to infants and children by age, race and ethnicity.
HOM 6: Child death rate.

Priority Need 5: Assure Quality Screening, Identification and Intervention

NEW SPM 5: Children enrolled in the Follow-Along Program.
NEW SPM 6: Children under the age of one year participating in early intervention
NPM 1: Newborn bloodspot screening follow-up.
NPM 12: Newborns screened for hearing before hospital discharge.
HSCI 02: Medicaid enrollees less than one year old receiving at least one initial or periodic screening
HSCI 03: SCHIP enrollees less than one year receiving at least one periodic screen

Priority Need 6: Improve Access to Quality Health Care and Needed Services

NEW SPM 7: Percentage of participants in Minnesota's family home visiting program referred to community resources that received a family home visitor follow-up on that referral.

NEW SPM 8: Percentage of children and youth with special health care needs that have received all needed health care services. (National Survey of CSHCN)
NEW SPM 9: Percentage of families of children age 0-17 that report costs not covered by insurance are usually or always reasonable.
NPM 2: Families partnering in decision making for CYSHCN.
NPM 3: CYSHCN receiving care in a medical home.
NPM 4: Adequate public and/or private insurance for CYSHCN.
NPM 5: A service system for CYSHCN that is organized and easy to use.
NPM 13: Children without health insurance.
HSCI 08: SSI beneficiaries receiving rehabilitation services
HSCI 05: Comparison of health system capacity indicators for Medicaid, Non-Medicaid, and all MCH populations
HSCI 06: Poverty level eligibility in the State's Medicaid and SCHIP programs
HSCI 07A: Potentially Medicaid-eligible children receiving services paid by Medicaid
HSI 09A&B: Infants and children enrolled in State programs by race and ethnicity

Priority Need 7: Assure Healthy Youth Development

NEW SPM 10: Identify a SPM and benchmark to monitor positive youth development
NPM 6: Youth with special health care needs receiving services necessary for transition adulthood

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	
Numerator	141	141	142	149	
Denominator	141	141	142	149	
Data Source				MDH Newborn Screening Program	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	100

Notes - 2009
We obtain our data from the newborn screening program, and their data has not been updated to 2009 yet.

Notes - 2008
Data from the Newborn Screening Program

Notes - 2007
2007 data not yet available

a. Last Year's Accomplishments
The percentage of newborns screened in calendar year 2008 was 99.2 percent with 71,682 infants screened during this time period. There were 762 presumed positive screening results and 158 confirmed positive results, including Amino Acidemias (11), Biotinidase Deficiency (9), Congenital Adrenal Hyperplasia (5), Congenital Hypothyroidiism (50), Cystic Fibrosis (13), Fatty Acid Oxidation Disorders (21), Galactosemia (8), Hemoglobinopathies (21) and Organic Acidemias (20). The breakdown of infants not screened includes 89 infants with parent(s) refused screening for the infant and 184 infants who died.

The Newborn Blood Spot Screening Program tests samples taken from newborns, notifies the primary physician of positive test results, tracks the results of confirmatory testing and diagnosis and links families with appropriate resources. This MDH program is operated as a partnership between the Public Health Laboratory Division and the Title V-CSHCN program.

Short term tracking (prior to point of confirmatory diagnosis) is the responsibility of the Public Health Lab with Lab staff providing education and information to the provider community. Roles and responsibilities are defined for short and long term follow-up activities for newborn blood spot and newborn hearing screening. The goal is to work toward a system of integrated data management and improved services to families. Resources available for families included primary care practitioners, pediatric specialists, genetic counseling, high-risk public health follow-up programs, early education, WIC, and health insurance coverage through publicly financed programs such as Medical Assistance (Medicaid) and MinnesotaCare. Follow-up includes collaborating with the University of Minnesota to successfully maintain a multidisciplinary clinic for individuals with congenital adrenal hyperplasia and associated conditions. Other activities occurring in this time frame include the provision of an up-to-date web-based list with recommended medically prescribed formulas and pharmacotherapy agents for inborn errors of metabolism; leadership, support, and technical assistance for two parent/family support groups: one for fatty acid oxidation disorders and the other for congenital adrenal hyperplasia and associated disorders.

Title V-CSHCN staff also collaborated with seven states in the Region 4 Genetics Collaborative (IL, KY, MI, MN, IN, OH, WI), identified data elements needed to monitor long-term outcomes for individuals with congenital adrenal hyperplasia based on the template for medium chain acyl-CoA dehydrogenase deficiency (MCADD). Minnesota infant and young children with metabolic disorders and congenital adrenal hyperplasia were enrolled in an online emergency care medical services information system (MCHB funded MEMSCIS). Approximately 280 families are participating in this ongoing activity.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide newborn testing as recommended by the State Newborn Screening Advisory Committee.	X			
2. Expand long-term follow-up activities to infants and their families for all NBS conditions.	X	X	X	X
3. Refine lab procedures for reducing false positive/negative test results	X	X	X	
4. Expand educational materials and activities to include all disorders identified by NBS bloodspot and early hearing detection and intervention	X	X		

5. Refine integrating data collection, infant follow-up and tracking, and program outreach with hearing screening program	X	X	X	X
6. Link identified infants and their families to community resources and a medical home	X	X		X
7. Support primary care providers, comprehensive centers and systems that care for infants and children with rare disorders.	X			X
8. Continue active participation on the Newborn Screening Advisory and Newborn Hearing Screening Advisory Committees				X
9. Implement linking blood spot and hearing data with birth/death certificates			X	X
10. Develop and implement an evaluation plan for program initiatives.				X

b. Current Activities

Ongoing planning, implementation and evaluation to determine long-term outcomes are extensive. Data elements for nineteen conditions have been developed including a disorder from each of the three major categories: amino acidemia, organic acidemias and fatty acid oxidation disorders. Conditions over time are being added to a secure, web-based platform, DocSite.

Minnesota staff began assessing means to track infants with endocrine, hemoglobinopathies, metabolic, pulmonary and hearing disorders found through newborn screening. Collaborations with partners and systems are integral to this activity. Statewide partners include primary care providers (Medical Home) population-based programs such as MCSHN, Universal Hearing Screening Program, high-risk follow-up programs, local public health, early education and families.

The major departmental policy issue during the current year was its response to legal issues raised on the issue of storing blood spots. Proposed legislation, supported by the Governor's Office would have limited the storage of blood spot cards to two years was not adopted by the Legislature. Concomitantly, a lawsuit was filed against the department for storing blood spot card of infants born in the past two years. The court dismissed the lawsuit with prejudice and that decision is now under appeal with oral arguments schedule to take place this summer.

c. Plan for the Coming Year

Staff will continue collaboration with partners to more effectively improve the needs of systems serving this population as well as providing information to families about a variety of services for infants diagnosed with a condition found through newborn screening. Collaboration, technical assistance and evaluation of needs of children with cystic fibrosis are a new focus now that Minnesota began screening for this disorder a few years ago. Minnesota has two nationally accredited centers and one seeking accreditation.

The Title V program will continue to support parent organizations, especially the two family groups for FAOD and CAH. The Region 4 Genetics Collaborative activities will support many aspects of collaboration with medical home providers. The state will remain an active participant in the seven work groups Of region 4 and its two competitive HRSA grants. The Public Health Lab is redesigning its management information systems. MCSHN created an internal data system to track those children with a diagnosis for long term follow-up. The Labs continue to add tests for additional conditions and follow up actions will have to accompany those additional tests.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**72382**					
Reporting Year:	**2008**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	71682	99.0	9	6	6	100.0
Congenital Hypothyroidism (Classical)	71682	99.0	150	50	50	100.0
Galactosemia (Classical)	71682	99.0	63	8	8	100.0
Sickle Cell Disease	71682	99.0	22	21	21	100.0
Biotinidase Deficiency	71682	99.0	74	9	9	100.0
Cystic Fibrosis	71682	99.0	266	13	13	100.0
Hemoglobinopathies	71682	99.0	39	21	21	100.0
Organic Acidemias	71682	99.0	37	20	20	100.0
Amino Acidemias	71682	99.0	34	11	11	100.0
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	71682	99.0	51	5	5	100.0
FAO	71682	99.0	48	21	21	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	63	63	63	63	63
Annual Indicator	59.1	60.3	60.3	60.3	60.3
Numerator	90109	103284	103284	103284	103284
Denominator	152468	171251	171251	171251	171251
Data Source				National Survey of CSHCN 05/06	National Survey of CSHCN 05/06
Check this box if you cannot report the numerator because 1.There are fewer than 5 events					

over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	63	65	65	65	65

Notes - 2009
Data source is the National Survey of CSHCN 2005/ 06

Notes - 2008
Data source is the National Survey of CSHCN 2005/ 06

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

2007 data not yet available.

a. Last Year's Accomplishments
The work by the parents as partners in the medical home collaborative had a definite impact on implementation of the state's 2008 health care home legislation. The health department formed a consumer-family council was formed to advise it on all areas of health care home implementation. This group met monthly during this time frame and participated in all work groups involved in health care home implementation.

Another major activity involving families during this time frame involved autism and the Somali community. There are high rates of participation of Somali children in early childhood special education programs in Minneapolis. This raised concern among Somali parents and educators that there was a higher rate of autism in the Somali community. In response, the Title V program directed epidemiological resources to analyze the Minneapolis data, resulting in the report "Autism Spectrum Disorders among Preschool Children Participating in the Minneapolis Public Schools Early Childhood Special Education Programs". Title V also sponsored a one-day forum for parents, providers and educators: "Autism in Somali Children: Building Partnerships to Improve Care". Both of the above activities on autism included the connections between services and families and family satisfaction with those services.

A focus of MCYSHN programs continues to be parent involvement in system-wide quality improvement activities. Lessons learned from parent participation in medical home are guiding parent participation in the EDHI learning collaborative, which held its first learning session in September of 2008 and the Developmental Disabilities and Autism learning collaborative that began in January 2010. Each of the teams in this quality improvement learning collaboratives is required to have a minimum of two parents per team. Parents receive on-going support and training in order to be active participants and are utilized as expert speakers to help professionals learn about needs and experiences of families in the various systems. The role of families on systems quality improvement teams help shape changes in the systems and result in greater family satisfaction.

MCYSHN district staff held 37 "Taking the Maze Out of Funding" workshops during SFY 2009 with a total of 716 attendees. Attendees included parents of children with special health care needs, local public health, education and human service providers and numerous private health and related services providers. The tools developed to determine which financial resources a child may be eligible for are particularly useful according to participant evaluations.

MCYSHN staff continued support and participation in the Parents as Teachers program -- part of the University of Minnesota's Pediatric Residency rotation in developmental disabilities. MCYSHN continued its collaboration with parent organizations such as Family Voices of Minnesota, Minnesota Hands and Voices and PACER, Inc.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Update MAZE training materials to reflect legislative, policy and procedural changes to programs.				X
2. Continue to target parents as a MAZE audience	X		X	X
3. Support primary care teams and their parent-members involved in the DD/Autism and EHDI Learning Collaboratives through Title V resources		X		
4. . Provide financial support for parent involvement in collaborative learning activities.		X		
5. Revise (as necessary) fact sheets for parents on genetic conditions of infants identified through the state's birth defects information system and newborn screening			X	X
6. Support outreach activities of the MnSIC process to parents on Interagency Coordinating Committee.				X
7. Continue leadership in the Part C program and support of parents on the ICC, Newborn Screening Advisory Committee, Newborn Hearing Screening Advisory Committee and the IEICs.		X		X
8. Support establishment of a strong Family Voices network in the state				X
9. Establish and support regional networks of parent leaders				X
10. Support Minnesota Hands & Voices to offer parent-to-parent support at time of hearing loss diagnosis.			X	X

b. Current Activities

The Title V program in Minnesota continues to promote parent/family/youth partnership and leadership. MCYSHN is taking a leadership role in promoting and enhancing family-centered care across Minnesota through partnership with families, providers, hospital systems, policy makers and other state programs. To support this work MCYSHN staff involved in health care reform implementation attended the Institute for Family-Centered Care Intensive training Seminar held in Minneapolis in October 2009.

At the practice level, parents as quality improvement partners are viewed as essential participants in the DD/Autism quality improvement learning collaborative and the EHDI Learning Collaborative. The Title V program has completed its five-year needs assessment and involved a diverse representation of families in the process of determining the final ten priorities.

MCYSHN continues to staff a toll free information and assistance line that serves as a resource for parents to understand and access services for their children and provides resources. A significant amount of work is being done to provide families with essential and helpful information on the web and through written materials for all families including materials and resources developed within MCYSHN program, materials and links from other organizations and programs serving families in Minnesota and, material developed by the Regional Genetics collaborative.

c. Plan for the Coming Year
MCYSHN intends to continue its commitment and begin a more formalized process for partnership with families of CYSHN along with its commitment to system-wide quality improvement to enhance the satisfaction of families with health care services.

Each unit within the MCYSHN will develop and add priorities to their respective work plans for the coming year to include specific activities around family involvement and the promotion of patient-and-family-centered care. Each unit will put in place activities and supports to assure the partnership and involvement of families in the care of their individual child; in program and policy development, implementation and evaluation throughout the systems of care for children and youth with special health care needs. There will be a focus on seeking funding to continue and expand quality improvement initiatives that include partnering with families to improve systems of care and to implement the following Family Involvement Plan.

MCYSHN will seek to enhance support and partnership with families. Such partnerships could include: a Family Council to provide input and guidance to all CYSHN activities including the development, implementation and evaluation of new projects, programs and materials; family representatives included in all MCYSHN program committees; development and execution of web-based surveys and family focus groups to determine family experience and satisfaction; family leadership training to assist families in preparation to participate in policy committees and/or ongoing family representation in MCYSHN staff meetings.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	53.6	53.6	53.6	54	54
Annual Indicator	48.7	51.8	51.8	51.8	51.8
Numerator	74252	88280	88280	88280	88280
Denominator	152468	170372	170372	170372	170372
Data Source				National Survey of CSHCN 05/06	National Survey of CSHCN 05/06
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	54	54	54	54	54

Notes - 2009
data source: National Survey of CSHCN 2005/06

Notes - 2008
data source: National Survey of CSHCN 2005/06

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

a. Last Year's Accomplishments
The past year has been one of transition for pediatric medical home as the state has put in place a process for certification of primary care practices as health care homes. The pediatric collaborative-hosted two final learning sessions, the January 2009 session focused on patient and family-centered care and the 2009 session focused on transition from medical home to health care home.

As part of Health Care Reform, implementation of health care homes became a state priority and its activities were co-managed by the Minnesota Departments of Health and Human Services. Health Care Homes are intended for patients of all ages and state law directs all those insured (except for Medicare and ERISA) should be eligible to participate in a medical home on a voluntary basis. RFPs were drafted and published with the assistance of Title V staff. Projects included one on assessing the capacity of the primary care system in the state to implement health care homes and one on evaluating collaborative learning models. Final reports from both activities were completed at the end of June. The Certification Work Group continued to meet during this time frame and made recommendations on a set of proposed rules for certification of practices as health care homes. These recommendations were reviewed internally and proposed rules for certification were adopted in January 2010.

MCYSHN district staff worked with Health Care Home staff to identify and support local clinics and physicians across the state interested in Health Care Home Certification. In addition, district staff are assisting with local trainings for interested physicians and clinics about the Health Care Home certification process.

MCYSHN staff facilitated and conducted quality improvement learning collaboratives with primary care/medical home providers to improve the quality of systems for children and youth with special health care needs. The Early Hearing Detection and Intervention Community Collaborative brings together members of the EDHDI system, parents and providers to remove barriers and increase access to early hearing detection, intervention and follow up. The Community Partnerships Collaborative for Autism and Developmental Disabilities focuses on improving early identification, diagnosis and referral system for young children with primary care, parents, special education and local public health screening as core partners upon which systems can build.

Staff continued to work with external stakeholders to educate and promote the concept of medical home, including University of Minnesota graduate and professional programs in the School of Public Health and School of Nursing and the Medical School.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Use "learning collaborative" approach to expand the number of children receiving coordinated care.		X		
2. Continue to partner with the state chapter of the AAP				X
3. Continue efforts to assure identified reimbursement strategies for medical home come to fruition				X
4. Continue efforts at integration of mental health services with medical home activities.	X		X	X
5. Promote concept of medical home through education of local				X

public health personnel				
6. Pursue curricula development about medical home with appropriate university programs				X
7. Work with state medical association, as it promotes medical home				X
8.				
9.				
10.				

b. Current Activities

The Title V-CSHCN program continues to pursue five broad strategies to promote medical home. First, it is working with colleagues in the health care home unit to promote certification of primary care practices as health care homes. Secondly, MCSHN continues to work with the state chapter of the AAP, the Center for CSHCN at the University of Minnesota School of Nursing, the School of Public Health, Family Voices of Minnesota and other major institutional stakeholders to inform and educate students, parents, providers and decision-makers about medical home and family-centered care.

MCYSHN will continue to work with its colleagues in the Public Health Lab (newborn screening) to improve those systems and to link families of infants diagnosed/identified through those systems with a medical home. MCSHN implemented a quality improvement learning collaborative with primary providers focused on improving systems of care for children and youth with developmental disabilities and Autism using the basic medical home principles outlined by the American Academy of Pediatrics.

The Early Hearing Detection and Intervention (EHDI) program continues its quality improvement learning collaborative to reduce loss to follow-up. Included in the collaborative sessions are the success stories in medical home and efforts to link infants diagnosed with a permanent hearing loss to a medical home.

c. Plan for the Coming Year

The MCYSCN program will seek funding to continue its leadership in quality improvement initiatives. While the state promotes the general advancement of medical home through its Health Care Home legislation and certification, MCYSHN will to continue its leadership in addressing the unique issues of children and youth with special health care needs in primary care and throughout all systems serving CYSHN.

MCYSHN will continue its partnership with the Minnesota Chapter of the American Academy of Pediatrics to enhance the understanding of the unique needs of CYSHN with primary care/medical home providers. This partnership will include participation on the Minnesota Child Health Improvement Partnership, MNSIC, the Minnesota Department of Human Services Screening Academies for primary care providers and other child serving entities.

The EHDI Community Collaborative will increase its focus on involving primary care in the EHDI system and assuring coordination of care for children with hearing loss among primary care and other members of the EHDI system.

MCYSHN district staff will continue to support and facilitate the connection of local primary care providers and clinics in understanding the Health Care Home certification process. MCYSHN staff and programs will continue to promote and assist families of children and youth with special health care needs.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	70	70	70	66	66.3
Annual Indicator	68.8	66.3	66.3	66.3	66.3
Numerator	104898	116294	116294	116294	116294
Denominator	152468	175428	175428	175428	175428
Data Source				National Survey of CSHCN 05/06	National Survey of CSHCN 05/06
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	66.3	70	70	70	70

Notes - 2009
Data source: National Survey of CSHCN 2005 / 06

Notes - 2008
Data source: National Survey of CSHCN 2005 / 06

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
Although not one of the final 10 priorities ultimately adopted in the 2005 Title V Needs Assessment process, insurance coverage was one of the top 15 priorities in each of the three population groups (CYSHCN, Women and Infants, and Children and Adolescents) analyzed in that process. Minnesota has always been a leader in insurance coverage of its children. State specific studies over the last ten years indicate 93-95 percent of children in this state have had health insurance during that time and that the majority of those without coverage are eligible for either Medicaid or MinnesotaCare. Data from 2006 indicated 67.5 percent of the state's population are privately insured (both fully-and self-insured) and 25.1 percent are insured through programs such as Medicare, Medicaid and MinnesotaCare compared to 62.2 percent privately insured and 28.7 percent publicly insured in 2009. Latest available data (2009 Minnesota Health Access Survey)) indicate 93.3 percent of children and youth under 17 have insurance. However, 22 percent of youth between 18 and 24 were uninsured, implying potential transition issues for CYSHN. The overall uninsured rate for the state in 2009 was 9.1 percent compared to 7.2 percent in 2007.

The issue of the adequacy of insurance for children in general, and CYSHCN in particular, has

never been as rigorously addressed as the question of whether children have any type of health insurance. The only studies analyzing adequacy of insurance are the National Survey of Children with Special Health Care Needs conducted in 2001 and 2005. The 2001 study indicated that 68.8 percent of Minnesota's children with special health care needs had adequate insurance at the time of the survey and the 2005 study indicated 70 percent had adequate insurance.

One area of continuing activity by the CYSHCN program is that its staff are instrumental in educating families and community professionals about eligibility and coverage criteria of publicly funded, health insurance programs. This activity, called MAZE trainings ("Who Pays? Taking the Maze out of Funding"), provided training to over 700 people through 37 different training sessions during the report year.

Staff also work closely with the Children's Mental Health Services division of the Minnesota Department of Human Services by supporting training sessions on the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood™ (DC:0-3™). This is a classification system developed by the Zero to Three organization and is based on the recognition that young children can experience social-emotional and developmental disorders and that a system for diagnostic classification sensitive to the developmental issues of young children was needed. It can also be used as a basis for third-party reimbursement since DC: 0-3™ codes can be converted to DSM-IV codes.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Analyze 2009 legislative changes in publicly-funded, state health insurance and waiver programs.				X
2. Update MAZE materials to reflect legislative policy or procedural changes to programs				X
3. Promote and conduct MAZE trainings statewide.		X		X
4. Integrate MAZE trainings as a resource into medical home activities.		X		X
5. Continue support of Children's Mental health Services initiatives and DC:0-3 Trainings	X		X	X
6. Maintain and enhance staff knowledge base about insurance, issues and implications.				X
7.				
8.				
9.				
10.				

b. Current Activities

Four activities have been directed to the issue of adequacy of insurance during the current federal fiscal year. Parents and professionals continued to attend MAZE trainings. Collaboration with Children's Mental Health Services of the Minnesota Department of Human Services (DHS) in sponsoring to DC: 0-3™ trainings continued throughout the state.

Effective January 1, 2009, the state received approval from CMS for payment to Provider-Directed Care Coordination activity. These are payments for physician services on behalf of fee-for-service Medicaid patients. This initiative is a result, in part, of the Title V medical home initiative. Staff continue to work with Health Economics staff of the department on using results from the biennial health access survey, which is the state's primary data source for defining and resolving policy issues surrounding health insurance.

c. Plan for the Coming Year
MAZE and logistical support for DC: 0-3™ trainings will continue. Given the on-going and multi-faceted efforts to segment health insurance coverage, it will be necessary for MCYSHN to develop expertise on insurance products such as Health Savings Accounts, Health Reimbursement Accounts and other forms of consumer directed health care products in order to provide timely and accurate information to families of CYSHCN on these issues. Finally, implementation of both state and federal health reform will require the MCYSHN program ensures linkages between those efforts and the Title V-CYSHCN program exist to ensure interests of CSHCN and their families are represented. As noted elsewhere, a department initiative on investing in children is developing a number of objectives, including one on the affordability of insurance coverage for families of children.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	78.5	78.5	78.5	91	91
Annual Indicator	73.5	90.7	90.7	90.7	90.7
Numerator	112064	160677	160677	160677	160677
Denominator	152468	177112	177112	177112	177112
Data Source				National Survey of CSHCN 05/06	National Survey of CSHCN 05/06
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	91	94	95	95	95

Notes - 2009
Data Source: National Survey of CSHCN 2005 / 06

Notes - 2008
Data Source: National Survey of CSHCN 2005 / 06

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

a. Last Year's Accomplishments

In 1998 Minnesota enacted legislation known as the Interagency Services for Children with Disabilities Act. Now referred to as the Minnesota System of Interagency Coordination (MnSIC) by its state and local partners, has as its purpose the "…development and implementation of a coordinated, multidisciplinary, interagency intervention service system for children" with disabilities ages birth through 21. This legislation affects all agencies and educational organizations working with these individuals and their families. A state appointed committee -- the State Interagency Committee (SIC) -- has been appointed to oversee implementation of this initiative at the state level. The MCYSHCN director is a member of this policy-making body.

The governing boards of the 96 local Interagency Early Intervention Committees (IEICs) located throughout the state are designated with the responsibility of designing and implementing their birth through 3 interagency system. The goal of this endeavor is to increase the level of coordination of services for the individual child and his or her family.

The Minnesota Department of Education (MDE) serves as the lead state agency for the implementation of the Part C (early intervention) program of IDEA. State staff continue to educate Part C primary referral sources on eligibility guidelines that include the definition of a condition with a high probability of resulting in a developmental delay, as well as the use of informed clinical opinion.

The MCYSHN program has an interagency agreement with the Department of Education that delegates the child find responsibility pursuant to IDEA to the Title V-CYSHCN program. The Infant Follow Along Program is the means by which this responsibility is implemented. The Follow Along Program is implemented at the local level primarily by local public health agencies. The program uses the ASQ and ASQ-SE screening tools. MDE also delegates the development of outreach efforts to primary referral sources in health care to the CYSHCN program. This includes the dissemination of current Part C eligibility to health care professionals, as well as information on making Part C referrals. MCYSHN district staff have direct relationships with local clinics and health care providers and assist in developing best practice policies on serving children with special health needs.

MCSHN staff conduct trainings called "Who Pays? Taking the Maze out of Funding" targeted to parents, professionals and advocates. Slightly more than 700 individuals attended 37 trainings during state fiscal year 2009. The content of the trainings provided up-to-date information about eligibility and coverage on the state's Medicaid program, the MinnesotaCare program and the state's home- and community-based waiver programs.

MCSHN supported the state's Birth Defects Surveillance program in three different ways. First, it reviewed and updated fact sheets on each of the 44 different birth defect conditions. Secondly, the Information and Assistance function of the MCSHN program linked families with resources. Lastly, MCSHN served as a back up for those local agencies that elected to be the first point of contact to link families with resources.

Another major activity involving families during this period involved autism and the Somali community. There are high rates of participation of Somali children in early childhood special education programs in Minneapolis, raising concerns in the Somali community about the rate of autism. Title V sponsored a one-day forum for parents, providers and educators: "Autism in Somali Children: Building Partnerships to Improve Care" to begin to address these concerns.

Several activities occurred within the EHDI program with a focus on improving systems. Three statewide EHDI learning collaboratives were held with regional teams, including parents making small changes to improve the overall system. Program staff also finished participation in the National EHDI collaborative that helped identify points in the screening-diagnosis-intervention continuum that need improvement at the state level to assure the earliest possible intervention

and reduce loss to follow-up.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to partner with other state agencies to fully implement the interagency coordination process				X
2. Update the searchable, web-based central directory for Part C		X		
3. Continue state support and technical assistance for the Infant Follow Along Program			X	X
4. Inform and educate providers, community professionals and parents about the ASQ-SE mental health screening component of the Ages and Stages Questionnaire			X	X
5. Continue active participation and leadership in statewide ICC, IEIC and Part C activities				X
6. Continue support of DC: 0-3 trainings			X	X
7. Support activities on autism			X	X
8. Continue support for EHDI collaborative and long-term follow-up activities	X		X	X
9. Continue support of the birth defects surveillance system at the state level and support of local public health at the community level	X		X	X
10. Partner with department of education in providing technical assistance and education for Part C eligibility guidelines.	X		X	X

b. Current Activities

The MnSIC activity described above is on going. Ongoing activities also continue within the EHDI program with a focus on system-wide quality improvement through collaborative learning sessions and partnerships with local public health. The birth defects surveillance activity is relocating to the Division of Community and Family Health, effective July 7.

Over the past year, Minnesota's Part C system has gone through a statewide identity transformation. "Help Me Grow" is the statewide public awareness and outreach initiative for infants and toddlers ages birth to three through Part C of the Act, and for ages three to five years through Part B 619 of the Act. MCYSHN staff, especially its district staff, continue collaboration with health care home colleagues in implementation of certification of clinics as health care homes.

A protocol for the confirmation of autism among Somali children who participated in the early childhood special education program during the years examined in the Somali Autism Report was developed. Opportunities for funding implementation are being examined. A cultural influences advisory group has examined some of the barriers and support to participation in such programs.

c. Plan for the Coming Year

The Title V-CYSHCN program continues its support of the MnSIC concept and activity because it believes there are many parallels between medical home and the MnSIC goal of interagency coordination including coordination of services, family-centered care and an increased role for parents in the decision-making process. The focus of MnSIC activity during the coming year will be on the transition of youth 18-21 and their employment and independent living needs. MCYSHN staff will continue to support the positive momentum in Minnesota's health care home (medical home) program development and implementation.

Due to a recent audit from the Office of Special Education Programs, Minnesota's current Part C structure of having 96 local interagency early intervention committees will be studied. A planning process will take place during the summer and fall of 2010 to identify ways that the planning and coordination of services for young children with special needs can be accomplished through a more stream-lined and efficient structure, with a focus on the timely referrals and service provision to children and their families

MCYSHN staff will continue to support the Follow Along Program and explore the use of online screening tools ASQ and ASQ-SE; provide targeted technical assistance and training to the health care and medical community around implementation of Help Me Grow, promote early hearing screening and referral, and provide technical assistance and family support for the birth defects surveillance system.

MCYSHN will continue to collaborate with Children's Mental Health Services through logistical support of DC: 0-3™ training sessions. Materials for the "Who Pays?" trainings will be updated and trainings will be provided free of charge to multi-disciplinary audiences.

MCSHN is engaged in a multi-division activity on the topic of integrated child health information systems. Its purpose is to establish a department-wide, coordinated approach to the analysis, planning and business case development of activities that will enable thoughtful and efficient progress towards creating greater interoperability across child health information systems within MDH. This will continue with special emphasis on further development of a management information system to track long-term follow-up of infants/toddlers/children that have been diagnosed with permanent hearing loss.

Lastly, MCYSHN submitted a request for funding to MCHB for a quality improvement initiative on autism and other developmental disabilities in June of 2010. One objective being improvement of linkage between families, physician practices and community resources. If funded, this initiative will begin in the fall of 2010.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	6.4	6.4	6.4	55	55
Annual Indicator	5.8	5.8	52.9	52.9	52.9
Numerator	8843		39459	39459	39459
Denominator	152468		74600	74600	74600
Data Source				National Survey of CSHCN 05/06	National Survey of CSHCN 05/06
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and					

therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	57	57	59	59	59

Notes - 2009
Data Source: National Survey of CSHCN 2005 / 06

Notes - 2008
Data Source: National Survey of CSHCN 2005 / 06

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

a. Last Year's Accomplishments
Participation on the State Transition Interagency Committee (STIC) continued. MCSHN district staff were active in local Community Transition Interagency Committees (CTICs) and worked with local public health agencies to keep them informed of proceedings and events. District staff communicated this information at local maternal child health meetings to help local public health nurses better understand the impact of health on transition. District staff presented information to school nurses on the impact that health, education and human services have on transition outcomes. Transition information continued to be distributed at MCYSHN's Development and Behavior Clinics when the age of the patient was appropriate. Adolescents are taught how to advocate for themselves and self care, social skills and transition to adult health among other interventions are discussed.

MnSIC is described in detail in NPM # 5. A MnSIC priority this year was the transition from special education to community-based services for young adults. The Minnesota Department of Education distributed a Transition Toolkit and MCYSHN provided information on health and transition and was also be a part of the planning and distribution. The Minnesota CSHCN Director was on the North Dakota Advisory Committee for implementation of its learning collaborative on healthy transitions.

The co-director of the Healthy and Ready To Work National Center served on the Medical Home Collaborative Leadership Advisory Committee. A Youth Network developed information on transition issues for the MCYSHN website. These young men and women, facilitated by the Co-Director of Healthy and Ready to Work, then presented this information at the May, 2009 medical home learning session, The presentation focused on their recommendations on information helpful to make a successful transition.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue involvement with MnSIC and interagency coordination activities				X
2. Continue to incorporate transition into health care home activities				X

3. Include transition expertise on medical home/health care home leadership group				X
4. Continue involvement with the State Council on Disability				X
5. Provide analysis of the MN Student Survey relevant to youth with special health care needs				X
6. Continue involvement with the CTIC			X	X
7. Provide information and assistance to individual callers seeking advice on transition planning	X			
8. Promote transition as a topic to be addressed by state professional medical organizations			X	X
9. Continue involvement with the North Dakota transition collaborative				X
10.				

b. Current Activities

The Taking the Maze out of Funding transition packet is updated annually and distributed throughout the state as part of Maze presentations. District staff offers technical assistance to local service providers, parents and youth on transition issues.

Early in the fall, there was an emphasis on H1N1 planning. Influenza vaccination was recommended for children and adolescents, especially those with special health needs. Those young men and women who are in a transition mode with their health care were targeted as a specific target population for education on the need to be vaccinated. MCYSHN District Staff were activated as back-up staff in MDH district offices once the regional emergency response operations centers were activated. MCYSHN Central Office staff were mobilized to cover both the health care provider and the public information telephone lines and provided office and administrative support to the data collection and surveillance operations of the department

c. Plan for the Coming Year

District staff will continue involvement in CTICs, Medical Home/Health Care Home teams, School Nurse and MCH meetings to address the implications of chronic disease and disability on youth with special health needs. MCSHN staff will serve on the state level transition advisory group.

The triennial Minnesota Student Survey was conducted in the spring of 2010. Once the data is available, analysis and dissemination of the survey relative to students with special health care needs will be priority area for MCYSHN. A great deal of effort and discussion regarding the question of identifying students with special health care needs resulted in dividing the original question "Do you have a physical or mental health condition that has lasted more than a year?" into two questions to allow analysis by physical condition or mental health condition. Previous surveys have demonstrated substantial disparities between youth with special health care needs and their peers, particularly in the areas of victimization (both at home and at school) and symptoms of depression.

The coordinator of the Healthy and Ready to Work National Center will continue to collaborate with MCYSHN and facilitate youth leadership activities. There will continue to be collaboration with colleagues in North Dakota as it implements its New Freedom Initiative state implementation grant focused on transition to work and independence for youth with special health care needs.

An interagency service matrix will be established to clearly define MnSIC participating agencies eligibility process, programs, services and payment sources to improve employment, and independent living outcomes for students with disabilities ages 18 to 21. It will clarify the relationship between the IEP/IIIP process and graduation requirements. In addition, it will define roles and responsibilities of MnSIC participating agencies regarding students with disabilities who

have identified long-term needs in employment and independent living, as well as clarify potential funding sources for employment and independent living services for youth 18 to 21 who have not graduated from secondary education

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	90	90	85	85
Annual Indicator	82.5	82.6	93.1	91.1	91.1
Numerator	55417	58242	65174	65124	65135
Denominator	67173	70511	70004	71486	71490
Data Source				National Immunization Survey	Estimates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	92	93	93	93	94

Notes - 2009
2009 data will not be available from MN Vital Statistics until 2011. These data are estimates.

Notes - 2008
2008 data not yet available.

Notes - 2007
2007 data not yet available

a. Last Year's Accomplishments
In Minnesota, the Title V program is not the lead entity for immunization activities. The immunization program is managed by the Infectious Disease Epidemiology, Prevention and Control Division. Title V staff collaborate with the immunization program by supporting and providing outreach and information, and providing immunization information to providers through Child and Teen Checkups (C&TC) trainings.

Minnesota continues work on Integrating Child Health Information Systems (ICHIS) involving immunization registry, vital records, newborn dried blood spot screening, newborn hearing screening, Birth Defects Information System, WIC, CYSHCN, blood lead program, and legal and system technology staff. Minnesota Department of Health (MDH) is still addressing issues around developing a unique child identifier. Immunization registry staff remain actively involved by offering input on their process for unique child identifiers. They have supported "pilot" attempts for ICHIS, using the immunization registry system to test possibilities of data matching across child

health program areas. This work will continue over the next several years as Minnesota works to meet its statewide e-Health goals.

Minnesota's immunization registry, the Minnesota Immunization Information Connection (MIIC), is a statewide network of seven regional immunization registries and services involving health care providers, public health agencies, health plans and schools working together to prevent disease and improve immunization levels. These regional services use a confidential, computerized information system that contains shared immunization records. MIIC provides clinics, schools, and parents with secure, accurate, and up-to-date immunization data. MIIC users can generate reminder cards when shots are coming due or are past due and can use the system to greatly simplify the work of schools in enforcing the school immunization law. In Minnesota, all parents of newborns are notified of their enrollment in MIIC through Minnesota's birth record process. An immunization information packet is given to all new parents in the hospital. They are given a toll-free number to call with questions or if they do not want to participate in MIIC. Very few individuals decline each month. Most declinations are due to a general objection to immunizations.

Although Minnesota's statewide immunization rate is consistently above the national average, there are pockets of under-immunized children in some high risk populations. The Eliminating Health Disparities Initiative (EHDI), established during the 2001 legislative session to close the gap in the health status of Africans/African Americans, American Indians, Asians and Hispanic/Latinos in Minnesota compared with Whites, supports grants to communities. One of the priority areas is increasing immunization rates. Eight of the grantees have chosen increasing immunizations as one of their goals. Activities this past year included conducting immunization clinics, awareness campaigns and education workshops and assisting individuals with accessing health care and referral services. Anecdotal information indicates increased immunizations by school entry and increased knowledge of the importance of immunizations among people of color and American Indians.

MDH provides support for increasing immunization rates in a variety of ways. MDH provides educational materials in English and other languages, provides educational opportunities for immunization providers around the state The Immunization Practices Improvement (IPI) program uses MIIC data in working with medical and other immunization providers. The focus of the IPI program is provider quality assurance. An IPI assessment is required of all providers. IPI hosts monthly conference calls with local public health agencies. In 2007, there were 377 IPI site visits conducted, 50 by MDH staff.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Target information on immunizations to high-risk populations.			X	X
2. Provide immunization training sessions to public and private providers through C&TC/EPSDT training.			X	X
3. Immunization review as part of WIC clinic services.			X	X
4. Support local community immunization registries.			X	X
5. Support MIIC strategic plan with emphasis on recommendations for integrating information with other child health data systems.				X
6. Support local immunization clinics.	X			
7. Support inoperability of data across various data sets. (Medicaid, WIC, Birth Certificates, Immunization Registry, BDIS, etc.).			X	X
8. Continue to work with the Office of Minority and Multicultural Health on improving immunization rates for racial and ethnic			X	X

populations.				
9.				
10.				

b. Current Activities
Title V continues to provide information and training on immunization related information to childcare, home visiting and C&TC providers. Immunization information is provided at conferences and to medical providers involved in C&TC. Information can be downloaded from the MDH web site. The immunization program, WIC and C&TC providers collaborate to link immunization information to improve vaccination coverage. MDH provides assistance to regional MIIC registries, hosts the web-based application, and manages its security.

During the fall of 2009 and early 2010, MDH staff played a lead role in coordinating H1N1 immunization efforts. MDH staff provided education to local public health and medical providers about high risk populations and vaccine availability. According to the CDC, Minnesota ranked 8th in the nation in the percentage of all residents who were vaccinated for H1N1 influenza. Twenty-six percent of children 6 months through 4 years living in Minnesota received two doses of H1N1 vaccine. Title V MDH staff from the MCH section also helped to staff the H1N1 information phone line to answer questions from providers, parents, schools and the public about H1N1. Title V staff also had roles as command and response staff during the management of the H1N1 vaccination program.

The Minnesota Department of Education maintains a website that provides current immunization schedules and information and collaborates with MDH staff to update this information as needed.

c. Plan for the Coming Year
Title V activities will continue as in the current year. In addition, immunization activities are supported and promoted through state and local family home visiting programs, C&TC and early intervention programs.

The Title V program will continue to work with EHDI grantees to address health disparities related to immunizations. The EHDI grant is currently in the process of determining and awarding funding for the next grant cycle. It is not known at this time if grantees will address immunizations with their grant funds.

MIIC regional immunization registry staff will continue to encourage an increase in the number of providers using MIIC. This level of provider "saturation" will continue to be tracked.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	13	13	12	13	12.5
Annual Indicator	12.5	13.8	13.9	12.9	13.1
Numerator	1365	1533	1519	1377	1400
Denominator	109134	110819	109548	106591	107000
Data Source				MN Vital Statistics	Estimates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over					

the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	12	11.5	11	11	11

Notes - 2009
2009 data will not be available from MN Vital Statistics until 2011. These data are estimates.

Notes - 2008
2008 data not available yet.

Notes - 2007
2007 data not yet available

a. Last Year's Accomplishments
Minnesota is using a total of $10.7 million in state and federal funds to support the Family Planning Special Projects (FPSP) grant program over two years beginning July 1, 2009. These funds are distributed through grants to local health departments (LHDs), tribal governments and non-profit organizations to support family planning services (outreach, public information, counseling, and method services).

Thirty-six percent of the funds support family planning services for teens. From July 2008 through June 2009, over 24,000 men and women received contraceptive methods from the 32 FPSP grantees. Thirty-three percent of females served were from populations of color and American Indians. MDH provided technical assistance to LHD to address teen pregnancy in their communities.

State funds support a family planning and sexually transmitted infection (STI) hotline staffed by individuals trained in information, referral, family planning, and STI counseling. Over 2,300 hotline calls were handled from July 2008 through June 30, 2009. Information on the hotline is mailed annually to Medicaid and Minnesota Care recipients.

The Title V funded Adolescent Health Coordinator provided technical assistance to the Minnesota Organization on Adolescent Pregnancy Prevention and Parenting (MOAPPP) for their annual conference. The coordinator distributed information on teen pregnancy prevention best practices and funding opportunities to over 1300 LHDs and community based organizations through the monthly Adolescent Health E-Newsletter. The coordinator received a small technical assistance grant for adolescent sexual health from the Association of Maternal and Child Health Programs (AMCHP) and National Association of City and County Health Officials (NACCHO). This funding established a partnership between MDH, a LHD, MOAPPP, and the Minnesota Department of Education to address disparities in a small rural community in southwestern Minnesota. Goals met from this opportunity include: increased collaboration between statewide and Nobles and Rock counties prevention professionals; increased capacity of Nobles and Rock counties to skillfully employ science-based approaches for teen pregnancy, HIV and STI prevention; and greater community support for teen pregnancy, HIV and STI prevention efforts.

Funding for the MN Education Now and Babies Later (MN ENABL) program ended in 2008. The remaining state dollars were granted to MOAPPP to support their Teen Outreach Program (TOP) and to provide further training and technical assistance on service learning and teen pregnancy prevention. In March of 2009, the Adolescent Health Coordinator and two professionals from MOAPPP were the first set of trainers outside of the state of Missouri certified to become Teen Outreach Program (TOP) trainers.

The Medicaid 1115 Waiver program, Minnesota Family Planning Program (MFPP) completed its third year. It had approximately 19,000 enrollees as of September 2009. Under MFPP, adolescents (15 years of age and above) are eligible for family planning services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide access to Family Planning Special Projects services.	X	X	X	
2. Partner with DHS to successfully implement 1115 Waiver for family planning services.			X	X
3. Increase public understanding of social, economic, and public health burdens of unintended pregnancy, especially to teens.			X	X
4. Develop public understanding and support for policies and programs that reduce unintended pregnancies.			X	X
5. Promote youth activities that support resiliency and healthy behaviors.	X		X	X
6. Support hotline for family planning and STI services .	X			X
7. Support school-based clinics and advocate for comprehensive sexuality education.	X			X
8.				
9.				
10.				

b. Current Activities

The Title V funded Family Planning Coordinator is conducting site visits to all 25 FPSP grantees during this time period to monitor their progress and provide technical assistance. A monthly newsletter is sent to all grantees with news of trainings and the latest research on family planning. MDH promotes the 1115 Medicaid Waiver and assist FPSP grantees in implementation of the waiver.

The Adolescent Health Coordinator provides technical assistance to MOAPPP on their annual conference. The coordinator distributes information on teen pregnancy prevention best practices and funding opportunities to LHDs and community organizations through an e-newsletter. Staff are writing a comprehensive adolescent sexual health data report, including common measures of sexual health such as STIs and teen pregnancy/birth rates, as well as some new data analysis. For example, staff is working with the Department of Human Services to find ways to approximate the rate of teen births among foster care youth.

Staff continues to provide one-on-one technical assistance to LHDs doing family home visiting to increase their capacity to address adolescent pregnancy prevention/youth development related activities.

Staff and American Indian community members are exploring evidence based approaches for working with the American Indian population on teen pregnancy prevention as a result of findings from an American Indian Infant Mortality Review Project.

c. Plan for the Coming Year

Continued coordination, collaboration and advocacy will be necessary to preserve and continue work on prevention of unintended pregnancy. Minnesota has a strong history of building on existing partnerships and shared resources to reduce teen pregnancy. MDH staff will continue to facilitate communication and collaboration with community partners on teen pregnancy prevention through a variety of vehicles. The Adolescent Health E-Newsletter provides research, resources,

funding opportunities and conferences on many topics related to adolescent health, including teen pregnancy prevention. Partnering with MOAPPP and Wyman Center on TOP replication issues, training, and service learning will also be a part of this coming year's activities. Rates of teen pregnancy and teen births will continue to be monitored and information disseminated on the most up to date information to LHDs and professionals statewide. The adolescent health coordinator will be on the planning committee for the MOAPPP yearly conference on teen pregnancy prevention. The Adolescent Sexual Health Data Report will be printed and disseminated by October 2010, and will serve as a springboard for statewide planning related to sexual health.

The Family Planning Coordinator will continue to provide technical assistance to FPSP grantees through a monthly newsletter and annual site visits. Staff will continue to help promote the 1115 Medicaid waiver and support family planning service providers in using the waiver. FPSP grantees, in partnership with MDH, will provide critical direct services to Minnesota adolescents in an effort to reduce teen pregnancy and teen birth rates.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	18	14	14.5	14	14.5
Annual Indicator	13.4	12.8	14.2	14.2	
Numerator	16420	16069	17235	18388	
Denominator	122626	125178	120950	129526	
Data Source				MN Dept. of Human Services	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	15	15	16	16	16

Notes - 2009
2009 DHS data will not be available until next calendar year (2011).

Notes - 2008
2008 data not available from the MN Dept. of Human Services until 3/1/10 .

Notes - 2007
2007 data not yet available

a. Last Year's Accomplishments
Minnesota does not have data on all third grade children who have received protective sealants on at least one permanent molar tooth. As a proxy, the MDH uses the number of children ages 8-12 enrolled in Minnesota's Medicaid or MinnesotaCare programs who had sealants placed on

one or more molar teeth during the past year.

Minnesota continues to have significant access issues for children who are uninsured or rely on Medicaid/ or MinnesotaCare coverage. Efforts have been directed at: 1) increasing reimbursement fees; 2) dental loan forgiveness programs and collaborative dental agreements to expand the number of available providers; and 3) grant programs to support innovative ways to assure dental access for low-income individuals.

According to the 2008 Local Public Health Planning and Performance Measurement Reporting System data, 58 percent (42 of 73) of Minnesota's local health departments (LHD) now have oral/dental health programs. Thirty-three percent (24 or 73) provide some health promotion or educational activities promoting oral/dental health. The remaining nine percent (7 of 73) do not have any oral/health programs or services.

MDH staff worked with the Minnesota Dental Association and the Department of Human Services on a state Oral Health Summit which was held on January 23, 2009. One of the major accomplishments of the summit was the development of a state oral health plan. The oral health plan identified stakeholders to form partnerships and a coalition to work at the workforce level on access to care and prevention education.

The Oral Health Screening e-learning training was updated in August 2009, and was utilized by C&TC providers across the state. It emphasizes the importance of oral health screening, discusses common oral health problems and abnormalities, and gives anticipatory guidance advice for providers in regards to oral health and prevention of dental caries. Additionally, Title V staff provided education and training resources for C&TC providers on dental screenings as part of the workshops.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Promote the use of dental sealants and other preventive measures to parents, health professionals and the general public.			X	X
2. Develop strategies that make it easier for children to receive sealants.			X	X
3. Promote and encourage school-based/school-linked sealant programs and appropriate follow-up.			X	X
4. Partner with the DHS to increase utilization of dental services for public program participants.			X	X
5. Incorporate preventive dental practices in the C&TC trainings.			X	X
6. Staff Oral Health State Plan Advisory Group.			X	X
7. Integrate oral health into Medical Home efforts.			X	X
8. Work with local public health and other stakeholders on improving children's oral health.			X	X
9. Continue to seek federal or other resources to support oral health promotion activities.			X	X
10.				

b. Current Activities

Title V staff continue to highlight the use of the "Schedule of Age-Related Dental Standards" for providers serving the Medicaid C&TC population. The schedule encourages dental exams at one year of age and ongoing oral/dental risk assessment. LHD staff are involved in activities to promote oral health, such as a complete oral exam (including 'lift-the-lip' procedure), fluoride varnish application, and oral health promotion with anticipatory guidance for parents and children.

Staff continued to work with the MDH Oral Disease Prevention Program staff on strategic planning work groups as part of the completion of a State Oral Health Plan by August 2010. Staff have participated in the "Prevention, Education & Awareness" work group as part of this process. Other stakeholders have taken part in work groups for "Access to Care" and "Workforce Development."

Fluoride varnish application and caries risk assessment was included in the C&TC refresher workshop for C&TC providers (March 2010) with the assistance of medical staff from the University of Minnesota. The 2009 C&TC Oral/Dental Health e-learning training continue to be used by public and private providers and was updated in April 2010.

Minnesota continues to implement activities for the CDC Oral Disease Prevention Program grant. Due to the ongoing nature of these activities, details are included in c. Plan for the Coming Year.

c. Plan for the Coming Year

Minnesota has received funding from the CDC for a 5-year Oral Disease Prevention Program (2008 through 2013). The Oral Health Program is housed in the MDH Center for Health Promotion. The grant's purpose encompasses eight areas: 1) Staffing: creating an oral health staff to increase infrastructure; 2) Surveillance: creating a surveillance plan and data collection to share information about the state's oral health needs; 3) Planning: creating a state oral health plan to strengthen the state's ability to promote oral health through purposeful, evidence-based planning, policy initiatives and development; 4) Partnerships: developing an oral health coalition with a focus on advocacy activities leading to sustainable oral health promotion activities; 5) Prevention: creating a school-based/linked sealant program to build the capacity of prevention programs, form partnerships to better utilize resources and lead to sustainable oral health promotion activities; 6) Policy: identification of opportunities to make changes in policy and health systems to overcome barriers, capitalize on assets, increase capacity and coordinate oral disease prevention interventions; 7) Evaluation: to measure program progress, community capacity changes and outcomes to improve Minnesota oral health and address disparities; 8) Integration: developing partnerships in oral health to promote leveraging of resources and coordination of effective public health prevention initiatives.

As part of the Oral Disease Prevention Program, an oral health surveillance team will be developed to coordinate data collection in cancer, birth defect, tooth loss, community water fluoridation, third grade student oral health, sixth/ninth/twelfth grader risk behaviors, emergency department statistics and workforce database accessibility. The maternal and child health epidemiologist has been invited to participate on the oral health surveillance team. The Oral Disease Prevention Program will continue to develop the systems for planning partnerships, prevention, policy making, evaluation of programs, and integration of effective public health initiatives as they relate to oral health in Minnesota.

The Oral Disease Prevention Program has also received a 3- year Workforce Innovation Grant from HRSA from 2009 through 2013, to assist in meeting the needs of underserved populations. The plans include developing 5 Collaborative Agreement E-Learning Trainings, following the completion of a needs assessment with dental providers. Other components will include a dental careers website for high school students, and a dental sealant program for migrants working with Smiles across Minnesota and Children's Dental Services.

The Title V staff involved in C&TC education training will continue to support and advance oral health promotion and screening as a priority in the Medicaid population. This will be accomplished through provider workshops, online resources, and state and local meetings.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	2.4	3.2	2.3	2	1.9
Annual Indicator	2.4	2.2	1.9	2.4	2.3
Numerator	24	23	20	25	24
Denominator	1005572	1030354	1035183	1035562	1035600
Data Source				MDH Injury Unit	Estimates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	2.3	2.1	2.1	2.1	2

Notes - 2009
The MDH Injury Unit will not have precise 2009 data until 2011. These data are general estimates.

Notes - 2008
2008 data not yet available.

Notes - 2007
2007 data not yet available

a. Last Year's Accomplishments
The motor vehicle crash child death rate (birth to age 14) of 2.41 per 100,000 in 2008 increased from the rate (and number of deaths) in 2007. This serves as a somber reminder for Minnesota to continue educational and enforcement initiatives, combined with providing car seats and booster seats to those who need them. Joint public safety and public health initiatives to reduce risk of injury in a motor vehicle-related crash include: 1) statewide distribution of car seats and booster seats to those in need; and 2) intensive training of public health staff and local volunteers in proper car seat and booster seat installation, combined with educational techniques and approaches for families to whom car / booster seats are given. These activities were accomplished in partnership and collaboration with Minnesota Safe Kids, the Department of Public Safety, local health departments and trauma centers across Minnesota.

More than 1,000 car seat safety specialists have passed child passenger safety training and are available to assist and to serve in communities across Minnesota. These specialists are listed by county on the searchable web site maintained by our partners at the Department of Public Safety, Office of Traffic Safety (http://www.dps.state.mn.us/ots/CPS_Program/childhome.asp).

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Distribute car seats and booster seats to families; teach proper installation and use.	X	X		
2. Train car seat and booster seat checkers.			X	X
3. Support the GDL and “Click it or ticket” campaigns of OTS, Department of Public Safety.				X
4. Support, through data analysis, the shift in MN to standard enforcement of seat belts (Every body, every seat, every time).				X
5. Continue emphasis in Positive Alternatives, Family Home Visiting and C&TC on using the home safety checklist with families being served.			X	X
6. Support enforcement of speed limits, prevention of distracted and drowsy driving, and reduction of impaired driving, which place children at risk.			X	X
7. Promote seat belt use for children.		X	X	
8. Promote safe routes to schools and walkable communities for children.		X	X	
9. Promote safe bicycling routes and practices for children.		X	X	
10. Promote crosswalk and pedestrian safety for children.		X	X	

b. Current Activities

Programs continued to distribute car/booster seats and train providers and parents on correct installation and use. Providers at clinics, hospitals and local health departments continue to encourage appropriate restraint usage in motor vehicles by all population sub-groups.

The C&TC program provides training sessions that includes guidance on safety issues including car seats and seat belt use. The best practice literature suggests that as health professionals champion motor vehicle safety as an aspect of their responsibilities, crash death rates will be reduced. Correct restraint needs to be modeled by parents and caregivers, taught by health professionals, and car/booster seats need to be provided to those who cannot afford them.

Excess speed, lack of seat belt use, distracted and drowsy driving remain concerns across all ages, but have particular impact on persons aged birth through 14 years of age. This has been Minnesota's first full year of enforcing our primary seat belt law and our strengthened booster seat law; impact analyses are still in progress to discern lives saved and injuries prevented. As of June 2, 2010, more than 100 of Minnesota's 128 acute care hospitals have been designated -- or are in the process of being designated -- as a Level I, II, III or IV trauma center. These improvements in Minnesota's EMS and trauma care systems will reduce the risk of motor vehicle crash-related death.

c. Plan for the Coming Year

Activities described in Current Activities will continue, with the addition of prevention partnership activities in and among Minnesota's minority populations through our state-funded Eliminating Health Disparities Initiative.

New funding for child car restraints and appropriate parental safety training has enabled local non-profit organizations to identify and support low-income families in the use of appropriate child restraints. However, the need far surpasses available funds and great gaps persist.

For families who do not qualify for an assistance program, new car seats can be found across Minnesota at various stores. If a used car seat is obtained, parents are encouraged to ensure that the seat is safe by assuring that the seat is less than six-years old and has never been involved in a vehicle crash. Parents are discouraged from using car seats missing the label with the manufacturing date, model number and original instructions, or one that has missing or broken

parts. Parents are advised to not purchase used car seats through garage sales or second-hand stores.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		45	48	48	48
Annual Indicator	46.5	46.5		51.6	
Numerator					
Denominator					
Data Source				NIS data	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	52	53	53	53	54

Notes - 2009
The most recent birth cohort available on the NIS website is 2006.

Notes - 2008
2006 is most recent birth cohort available on NIS web site. Data from the 2006 cohort is recorded under 2008 because 2007 is not accessible on this screen. Additional NIS data may be available in August 2010.

Notes - 2007
2007 data will not be available until 8/09 on NIS web site.

a. Last Year's Accomplishments
Minnesota continues to strongly promote breastfeeding of all infants and address challenges to initiation and continued breastfeeding. Minnesota has met and exceeded the Healthy People 2010 goal of 50 percent of mothers who are breastfeeding their infants at six months of age.

In other breastfeeding success measures, Minnesota has met the Healthy People (HP) 2010 goal for breastfeeding initiation and the department continued to work to promote and support breastfeeding for all Minnesota mothers and infants. Breastfeeding initiation rates for some population groups, including refugee and low-income populations, remain low. The Hmong and Somali populations have lost breastfeeding traditions upon immigration to the United States, Hmong women often cease to breastfeed and the Somali usually initiate breastfeeding at birth but often supplement and have shorter duration than before immigration. Native Americans also breastfeed at lower rates than the general population. Rates vary considerably between Minnesota communities. We have made progress, but barriers to breastfeeding remain.

Breastfeeding is encouraged and supported through MDH Family Home Visiting (FHV) program, and other local health department activities, including breastfeeding support groups and educational offerings. Breastfeeding materials, such as best practices and resources, were

distributed through FHV e-mail lists and posted on the FHV website. The Minnesota WIC program implemented multiple activities to promote and support breastfeeding.

Breastfeeding information for parents and professionals is available on the Minnesota WIC website. Minnesota now has 23 local breastfeeding coalitions. Breastfeeding information is available in English, Spanish, Somali and other languages.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assure that MCH Public Health Strategies on breastfeeding promotion continue to be available.			X	X
2. Support breastfeeding promotion and support as a component of the Family Home Visiting services.	X			X
3. Continue to provide breastfeeding education and support through WIC, i.e. training and technical assistance to local WIC programs, and local programs provide breastfeeding support services to WIC participants.	X		X	X
4. Provide technical assistance and training to local programs to help them identify opportunities and implement strategies to promote and support breastfeeding.			X	X
5. Continue WIC Peer Breastfeeding Support Grants and TA to grantees.	X			X
6. Convene cross-program meetings to identify ways to integrate breastfeeding promotion & support into a wide array of MCH programs.				X
7. Propose policies that support breastfeeding.			X	X
8.				
9.				
10.				

b. Current Activities

Title V and WIC program staff continue to collaborate to promote and support breastfeeding. Local health departments advocate breastfeeding and implement breastfeeding promotion strategies with families as well as support mothers with breastfeeding concerns and questions. Breastfeeding materials are distributed through FHV e-mail lists and posted on the FHV website.

WIC provides leadership for activities to promote and support breastfeeding. WIC continues to offer workshops on breastfeeding counseling. Breastfeeding information is available on the WIC website.

The Minnesota Breastfeeding Coalition (MBC) held its third statewide meeting in October 2009. The MBC works to build coalitions between public agencies, non-profits, hospitals and other organizations that promote breastfeeding. The MBC received its first federal grant from the Maternal Child Health Bureau to address worksite lactation support. The Business Case for Breastfeeding grant supported a two-day training in November 2009 and provides funds to implement or improve worksite lactation programs in businesses.

The MBC assisted the MDH Chronic Disease Risk Reduction Unit and Wilder Research to plan a research project. The project held focus groups and key informant interviews with Somali, Hmong, American Indian and White women asking about breastfeeding initiation, barriers, and work related breastfeeding concerns. The focus groups and interviews have been completed and data is being analyzed.

c. Plan for the Coming Year
MDH will continue to develop linkages to promote and support breastfeeding, including meetings between Title V and WIC staff to discuss breastfeeding promotion and support, and practices within communities that can hinder breastfeeding. Staff will also continue to place special emphasis on our newest cultural/ethnic populations. Staff plan to investigate collaborating on breastfeeding training and explore way to incorporate information on breastfeeding and cultural practices for breastfeeding into the training being developed for family home visitors. Staff will continue to provide current and relevant breastfeeding information to local public health staff, and work on the consistency of breastfeeding messages between programs and between program staff and communities.

The MBC will continue to implement the Business Case for Breastfeeding grant throughout Minnesota. Further trainings will be provided around the state on the Business Case for Breastfeeding resource tool-kit. Funds in the form of mini-grants will be available for implementation of business lactation programs. A worksite recognition program is being developed in collaboration with the Minnesota Obesity Program worksite wellness staff.

The Minnesota WIC Peer Breastfeeding Support Program is expanding and is planning to increase the number of counties in Minnesota providing peer breastfeeding support. The goal is to institutionalize peer counseling in WIC as a core service focused on increasing breastfeeding rates among WIC participants. Currently there are four peer support programs covering ten counties.

MDH will provide breastfeeding information and resources to Positive Alternatives grantees. Positive Alternatives is a grant program designed to support women in maintaining their pregnancies and supporting their infants after birth. The programs funded through Positive Alternatives are in a position to encourage and support women who choose to breastfeed.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	98	98	90	85	90
Annual Indicator	85.2	80.2	88.9	96.7	
Numerator	59657	60683	65434	69790	
Denominator	70030	75656	73608	72169	
Data Source				MDH newborn screening program	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	97	97	97	97	97

Notes - 2009
2008 is most recent data available from the MDH newborn screening program.

Notes - 2008
data not available for 2008

Notes - 2007
2007 data not yet available

a. Last Year's Accomplishments
The Minnesota Children and Youth with Special Health Needs (MCYSHN) section is collaborating with key stakeholders to implement a quality improvement project called the EHDI Community Collaborative. The overall aim of the Collaborative is to reduce the rate of loss to follow-up regardless of its cause at all levels of the hearing screening process. Accomplishments in the last year include increased parent partnerships, enhanced capacity and coordination of public health, education, social service and parent-to-parent support systems to create and sustain effective community based systems of care. The measures that were adopted reflect that all newborns will receive timely referrals, complete diagnostic evaluations, and appropriate linkages to all supportive services and resources. Six of the state's sixteen regional EHDI teams have participated in the collaborative by attending learning sessions, regular local team meetings, monthly conference calls, and monthly reporting data to the state.

In 2008, 96.3 percent (69,544/72,231) of newborns were screened for hearing. Results are reported on the dried blood spot form and then matched with birth certificates. About 2 percent (818/69,544) of newborns had a refer result on their hearing screening. During this time period 199 infants were reported to have a hearing loss and 106 of those infants had permanent hearing loss.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide technical assistance on implementing newborn hearing screening to hospitals, and communities.				X
2. Provide education and training of providers, including Audiologists		X	X	X
3. Provide information to parents of the importance of screening and if identified with a hearing loss, additional follow-up.		X	X	X
4. Refine and expand the data tracking & follow-up system			X	X
5. Integrate data collection, follow-up and tracking with other child health data systems.			X	X
6. Work with a variety of stakeholders on assuring follow-up, referral and intervention for infants.		X	X	X
7. Continue federally funded grant activities in this area.		X	X	X
8. Continue partnership with Hands & Voices		X	X	X
9.				
10.				

b. Current Activities
EDHI follow-up staff continue to work with their counterparts in the lab to improve hearing screening protocols and outcomes. MCYSHN-EDHI and Lab staff continue working on a major revision of the Lab's information system for short term follow-up. Children with a diagnosed permanent hearing loss will be tracked until the age of 18 years per the state legislation passed in 2007. The EHDI collaborative will continue into the next year and will add regional teams. Four

more learning sessions are planned and will focus on partnerships and using the model for improvement to decrease the number of infants who are lost to follow-up.

MCYSHN staff are working with representatives from the Minnesota Departments of Education and Human Services, Minnesota Hands & Voices, and the Commission of Deaf, DeafBlind and Hard of Hearing Minnesotans to produce four bi-lingual 60-minute television video broadcasts on Early Hearing Detection and Intervention. Emergency Community Health Outreach is a proven multi-media campaign that can widely disseminate a public health message to immigrant/refugee communities that address language and cultural barriers. Each video broadcast, which will include a question-and-answer segment with guests who are native speakers, will be broadcast during 2010 and placed for an indefinite period on the ECHO Web site.

c. Plan for the Coming Year

The MCYSHN program will continue to evaluate the outcomes from the EHDI Community Collaborative to determine if it continues with the teams. The collaborative will have submitted data to share and hopefully demonstrate regional and state improvements in all areas. In addition, a new web-based reporting system will be tested and piloted for local public health, audiologists, primary care providers, and early interventionists. The new system will provide an opportunity for data integration with other child health data systems, such as vital records, immunization, birth defects and WIC to assure that children are not lost to follow-up in the EHDI process.

MCYSHN staff will continue working with representatives from the other state agencies, Minnesota Hands and Voices, and the Commission of Deaf, DeafBlind and Hard of Hearing Minnesotans to recommend policy and system changes that improve the outcomes for newborn screening including those who have a permanent hearing loss.

The department will be contracting to assure that every family with a child diagnosed with a hearing loss will receive a call from a parent who has a child who has already been identified as having a hearing loss. The parent guides are able to direct parent-to-parent support linking families with resources in their area. Minnesota Hands and Voices has parent guides in all regions in the state.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	2.2	7.5	7	5.5	5.5
Annual Indicator	7.9	6.0	6.0	6.0	6.7
Numerator	97554	75476	75600	75450	85000
Denominator	1229578	1254930	1257000	1257900	1259500
Data Source				2006 MN Health Access Survey	2009 MN Health Access Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of					

events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	6	6	6	5	5

Notes - 2008
2008 data not available. Survey is not conducted every year.

Notes - 2007
2007 data not yet available

a. Last Year's Accomplishments
The Minnesota Department of Health (MDH), in partnership with the University of Minnesota, has periodically conducted the Minnesota Health Access Survey over the last 12 years. These surveys are the source of data for state policy makers to define and respond to health insurance issues of Minnesotans and are stratified random digit dial telephone surveys that include both cell and landline telephones.

The most recent survey, conducted in the fall of 2009, reports a significant increase in Minnesota's rate of overall uninsurance. In 2009, 9.1 percent of Minnesotans were uninsured compared to 7.2 percent in 2007. Of the approximately 480,000 uninsured Minnesotans, 85,000 were children compared to 75,000 uninsured children in 2007. This increased the rate of uninsured children birth to 17 from 6.0 percent in 2007 to 6.7 percent in 2009. Minnesotans covered by publicly-funded state programs like Medical Assistance (Medicaid) or MinnesotaCare increased from 25.2 percent in 2007 to 28.7 percent in 2009.

At the end of each legislative session, Title V CSHCN staff update MAZE training materials. MAZE stands for Taking the MAZE out of Funding. These materials reflect eligibility criteria and benefits coverage for Minnesota's publicly-funded health insurance programs, which include Medical Assistance (Medicaid), MinnesotaCare, home and community-based waivers. Title V CSHCN staff then conduct trainings throughout the state for providers, social service staff and families. In 2007-08, staff trained 978 people in 45 trainings. Over the past 5 years (2003-2009) nearly 5,000 people have been trained in 213 trainings.

Staff in the Family Home Visiting, Positive Alternatives Program, Family Planning Special Projects and WIC programs continued to emphasize to grantees the importance of assessing insurance status and the referral of clients to appropriate insurance resources. Title V staff also provide technical assistance and support to local health departments (LHDs) on insurance billing and eligible services.

Minnesota's local health departments are required to report on their progress toward increasing the number of clients enrolled in health insurance programs. To measure their progress LHDs report annually on those programs in which they routinely assess the health insurance status of clients. Following is a summary of their performance for 2009 in the programs that are most likely to reflect on the insurance status of children: Early intervention service coordination for CSHN (78 percent); WIC clinics (86 percent); Family home visiting (93 percent); C&TC (EPSDT) Outreach (86 percent); and Follow-Along Program (70 percent).

Also at the local level, family home visitors assist families with accessing insurance. This includes working with families to complete paperwork, assisting with selecting a provider and providing follow-up to assure that applications are completed.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide MAZE trainings for parents and professionals.		X		X
2. Partner with DHS to assure that all children eligible for public programs are enrolled.		X	X	X
3. Work within existing systems to assist families in identifying insurance options.				X
4. Update and distribute the Part C Central Directory.			X	X
5. Maintain insurance coverage component of the Family Home Visiting program.			X	X
6. Develop communication plan for using information related to health insurance to educate and inform providers, families, planners and policymakers.				X
7. Participate on Department priority area of Health Care reform activities.				X
8. Continue to monitor insurance referral reporting in local public health programs.				X
9.				
10.				

b. Current Activities

The 2008 Legislature, responding to a $1 billion deficit in its SFY 2009 budget considered a number of proposals affecting eligibility for Medicaid and MinnesotaCare. Changes passed by the Legislature and adopted by the Governor were analyzed and incorporated into the MAZE training. Preliminary results of the 2009 Health Access Survey were published in February of 2010 and are being used in policy decisions affecting eligibility criteria for children's enrollment in Medicaid and MinnesotaCare.

Minnesota's LHD continue to assess the insurance status of clients in multiple public health programs, including home visiting, WIC, early intervention services, C&TC, and the Follow-Along Program. MDH will support LHD in this effort. LHD will also continue to assist clients in obtaining adequate insurance.

The Commissioner of the MDH and its senior management undertook an agency strategic planning process in late 2009 and early 2010. The impact of this on the coming year will be explained below.

Title V staff are preparing for changes brought about by the federal 2010 health reform legislation as well as 2009 state health reform legislation, including standard benefit set definitions. Staff are monitoring the impact on Title V programs and preparing to address requirements from the legislation that will impact the insurance needs of mothers and children in Minnesota.

c. Plan for the Coming Year

MAZE training material will be updated throughout the summer based on legislative changes from the 2010 Minnesota legislature and changes resulting from federal health reform. Beginning in late 2010, Title V staff will conduct trainings throughout the state on eligibility criteria and benefit coverage of the state's publicly-funded programs. Title V staff continue to work closely with their Title XIX colleagues on a myriad of topics and program implementation challenges and will continue to do so.

The MDH will continue to work with LHD to monitor rates of insurance referral reporting of clients in public health programs as a way to monitor progress toward the statewide goal to increase the number of clients who are enrolled in health insurance programs.

A department-wide strategic planning activity was described above. This process resulted in the adoption of five "framework goals" for the department, including one focused on "help(ing) all people get quality health services." Three goal statements for each framework goal were then adopted, including one that states:"(a)ll Minnesotans have affordable coverage for the health care they need" In May of 2010, the Commissioner began an initiative entitled "Investing in Children". The first step in this process was the adoption of a number of objectives related to the above referenced goal statements. Among other objectives recommended to the Commissioner was one that would "(i)ncrease the percent of children who have affordable, adequate private and/or public insurance coverage and who do not experience significant financial barriers to the services they need." The coming year will see metrics developed to measure the objectives recommended to the Commissioner and implementation plans to help achieve the objectives.

Women enrolled in Medical Assistance or MN Care are automatically income eligable for WIC. Local WIC programs will continue to enroll families based on this criteria.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		29	28.5	28	28
Annual Indicator	29.7	30.4	29.9	30.4	29.9
Numerator	16723	17502	18272	19944	20630
Denominator	56307	57609	61109	65607	68997
Data Source				PedNSS	PedNSS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	27	26.5	25	25	25

Notes - 2008
2008 data not yet available.

a. Last Year's Accomplishments
The Minnesota WIC program continues to ensure that local WIC programs assess the weight status of all children participating in WIC, and tracks the incidence of children who are overweight throughout the year and across years via reports. Additionally, the Minnesota WIC Program disseminated the most recent CDC Pediatric Nutrition Surveillance System (PedNSS) report, which summarizes Minnesota WIC data (in total and by racial/ethnic group) over time through 2008, and compares Minnesota data to a national cohort. One of the data elements included in the report is childhood overweight and obesity.

The Minnesota WIC program rolled-out the new WIC food package between August and October 2009.
It offers a greater variety of nutritious foods (including whole grains, and fruits and vegetables), and promotes lower/reduced fat dairy options for children. In anticipation of the new food package, the Minnesota WIC Nutrition Education Plan for FY2009-2010 focused on activities

related to the new foods, in particular promoting fresh fruits and vegetables and lower fat diary-foods. Minnesota WIC program policy allows children over 2 years of age to receive only 1% or fat-free milk (i.e., disallowing 2%-milk) and limits the amount of cheese children may receive. Additionally, the foundation upon which the new food packages are based is the assumption that full (exclusive) breastfeeding is the expected infant feeding. The Minnesota WIC program has increased efforts to promote and support breastfeeding initiation and longer duration.

The revised WIC vendor requirements, including that WIC-authorized stores carry specified amount of low-fat milks and fresh fruits and vegetables, has changed the "food environment" in many small stores throughout the state.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Weigh and measure (twice/year) children ages 2-5 participating in WIC, plot data on growth grids and calculate BMI.	X			
2. Identify children at-risk-of-overweight or overweight, using BMI.	X			
3. Provide referrals to primary health care provider and other health and social services as needed.	X			
4. Counsel caregivers and provide nutrition education (e.g. related to feeding practices, diet and physical activity).	X	X		
5. Tailor the WIC Food package to best meet child's dietary needs.	X	X		
6. Transmit anthropometric data to CDC for PedNSS reports.				X
7. Share anthropometric data summaries with local and state stakeholders to guide policy decisions.				X
8. Participate in development of Obesity State Plan.			X	X
9. Incorporate appropriate referral mechanisms to WIC from other child programs such as home visiting, Follow-Along Program, Positive Alternatives grantees, etc.			X	X
10. Provide obesity prevention and screening education and training to pediatric C&TC providers.		X	X	

b. Current Activities

The Minnesota WIC Program is implementing a new initiative, "Participant Centered Education", intended to build WIC staff skills to more effectively engage, counsel, educate, and influence food choices, feeding practices, and other weight-related behavior changes. Local WIC leadership and staff recognize the need for better counseling skills, particularly in working with parents around sensitive issues such as childhood overweight.

To enhance local WIC capacity to better meet WIC participant nutrition needs, the Minnesota WIC Program made training funds available to local agencies to be used for WIC staff in areas of maternal and child nutrition, breastfeeding and counseling. In conjunction with the funds, agencies were notified of trainings available in each of these areas, including numerous trainings specifically addressing childhood obesity. Local agencies are currently taking advantage of these training opportunities.

The MDH has renewed its focus on breastfeeding. Activities include: data analysis and tracking; promoting and supporting staff training in breastfeeding management; expanding WIC peer breastfeeding support programs; collaborating with other programs in the MDH and with external partners.

The MDH has two additional activities to address obesity in children. These include the

Minnesota Obesity Plan and the State Health Improvement Partnership. Both are ongoing projects and described in c. Plan for the Coming Year.

c. Plan for the Coming Year
The Minnesota WIC program will be engaged in strategic planning to create and maintain enthusiasm and momentum in "Participant Centered Education" and in breastfeeding.

In July of 2008, the MDH released the Minnesota Obesity Plan for 2008-2013. This plan outlines a number of goals and objectives to be carried out by many sectors, including government, education, healthcare, media, industry, worksites, community organizations and others. Several of this goals and objectives are related to obesity in children.

The new Minnesota Statewide Health Improvement Program (SHIP) is supporting local public health departments and tribal governments to address the issues of obesity, physical activity and tobacco use. The MDH awarded 39 grants to Minnesota communities to help lower the number of Minnesotans who are obese or overweight or use tobacco. The $47 million appropriation for the SHIP covers 86 counties and eight tribal governments for the next two years through grants and technical assistance. SHIP interventions must be selected by local communities to address policy, systems and environmental change in schools, communities (including child care), worksites and health care. A number of these interventions are focused on children.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		13	13	13	13
Annual Indicator	14.9	13.6	15.0	11.6	
Numerator		9427	10303	7865	
Denominator		69367	68911	67563	
Data Source				MN PRAMS	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	11	10	10	9	8

Notes - 2009
Most recent PRAMS data available from CDC is 2008.

Notes - 2008
2008 PRAMS data not yet available.

Notes - 2007
2007 data not yet available

a. Last Year's Accomplishments

Title V staff continued to participate in quarterly training for new WIC staff and provide information on "2As and an R" (Ask, Advise and Refer) and other smoking cessation resources they can incorporate into WIC counseling. WIC staff were encouraged to refer participants to Minnesota's QUITPLAN? program and to provide information on protecting infants, children and pregnant women from secondhand smoke. WIC staff provided toolkits with resources on smoking cessation in pregnancy and postpartum, referrals to QUITPLAN? and reducing secondhand smoke.

The State Team on Smoking Cessation for Women of Childbearing Age continued to disseminate professional and patient education materials to local health departments (LHD) and community-based organizations through the "Save A Bundle" project. The materials include information on implementing the 5 A's, referring to Minnesota's QUITPLAN? for cessation phone counseling, preventing postpartum relapse and reducing secondhand smoke.

Title V staff trained Positive Alternative grantees on the 5 A's and provided resources to refer their clients to QUITPLAN?. Training was also provided on approaches to reducing infant and child exposure to secondhand smoke. This was integrated with training on safe infant sleep and SIDS risk reduction. Toolkits were provided to each grantee.

Title V staff partnered with the the Minnesota SID Center to train doulas on safe infant sleep, SIDS risk reduction, 5 A's for smoking cessation in pregnancy and postpartum, and reducing infant and child exposure to secondhand smoke. The training emphasized the specific connections between SIDS risk and smoking in pregnancy and household smoke. Resources were provided in a toolkit. This training was repeated for Twin Cities Healthy Start staff.

Staff facilitated a work group on reducing SIDS and promoting safe infant sleep as an activity of the Community Action Team implementing recommendations from Minnesota's American Indian Infant Mortality Review Project. SIDS/SUID is the leading cause of death of American Indian babies. American Indian women have the highest rate of smoking during pregnancy of any of Minnesota's populations at about 38 percent. In the review project, 46 percent of mothers smoked. In addition, infants and children are often exposed to secondhand smoke because of high rates of smoking in the population as a whole and the sovereign status of reservation communities and properties that are not subject to Minnesota's Freedom to Breathe Act of 2007, which eliminated smoking in all indoor public spaces. The work group learned from the community that messages about smoking cessation were not acceptable at this time, as smoking is a culturally sensitive topic. However, providing culturally specific messages about reducing infant and child exposure to secondhand smoke was an acceptable approach. Staff promoted the use of window clings stating "Smoke Free Home" and "Smoke Free Car" with the Healthy Native Babies logo as well as the other messages of the American Academy of Pediatrics' Safe Sleep Top Ten.

Maternal and Child Health (MCH) staff from LHDs were trained on smoking cessation in pregnancy and postpartum and reducing infant and child exposure to secondhand smoke. These trainings were conducted in greater Minnesota where PRAMS data indicate women smoke in pregnancy at rates twice as high as in the metro counties. All participants received toolkits and were offered ongoing technical assistance and resources.

Staff provided technical assistance to three of the state's eliminating health disparities in infant mortality grantees who primarily serve the Somali community. Technical assistance was tailored to the needs and understanding of the Somali community health workers administering the program. Very few Somali women smoke, especially during pregnancy or around infants and children. Those that do smoke are very secretive because it is against their culture and a difficult topic to approach. However, many Somali men smoke so pregnant women, infants, and children are frequently exposed to secondhand smoke. Resources and toolkits were provided to the program staff to help encourage a reduction in exposure to secondhand smoke for their vulnerable populations.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Access MN vital record, PRAMS and WIC databases for baseline incidence of smoking in pregnancy and ethnic/racial disparities.			X	
2. Implement with partners the Smoking Cessation for Women State Plan.		X		X
3. Repeat and extend training for smoking cessation.			X	X
4. Reach out to diverse community partners for training opportunities.			X	X
5. Work with others within the Department (OMMH) and external partners, (ACOG and midwives) to identify strategies on effectively reaching high-risk populations.				X
6. Integrate the "stop smoking" message with other health promotion messages targeted to young women.			X	
7.				
8.				
9.				
10.				

b. Current Activities

Staff provides support to LHD on the "5 A's" for smoking cessation. Toolkits and resources for implementation are provided.

Staff work to promote the safe sleep campaign and SIDS risk reduction with the MN SID Center. Smoking cessation is integrated into messages. Twin Cities Healthy Start focuses on smoking reduction in pregnancy and secondhand smoke reduction to reduce infant mortality, low birth weight, SIDS and other sleep-related infant deaths. Staff conducted a workshop on smoking cessation at the Strong Foundations (Birth to Three) Conference. The conference promotes the importance of building strong families to support children in their earliest years.

Staff provided an education session on the impact of smoking on pregnancy and infant health to participants American Indian women's group. Staff supports culturally specific messages for the American Indian population to reduce exposure to secondhand smoke and continues to distribute Healthy Native Babies window clings with the smoke free home and car messages. Many of these were distributed at the American Indian Infant Mortality conference, sponsored by Leech Lake, White Earth and Fond du Lac Bands of Ojibwe.

New grantees funded by the MDH Office of Minority and Multicultural Health to eliminate health disparities, including disparities in infant mortality, are anticipated to begin work in July. It is expected that some grantees will need ongoing technical assistance.

c. Plan for the Coming Year

Title V staff will continue to work with multiple partners to address smoking during pregnancy and postpartum and reducing pregnant women's, infants' and children's exposure to secondhand smoke.

One significant opportunity is the implementation of the Statewide Health Improvement Partnership (SHIP). The 2008 Minnesota Legislature passed comprehensive legislation to support SHIP providing funding ($47 million over the next two years) through grants to local health departments and tribal governments across Minnesota. Grantees are required to create

community action plans, assemble community leadership teams, and establish partnerships. Grantees utilize policy, systems and environmental changes in four settings: schools, work sites, health care and community. SHIP efforts focus on obesity (through physical inactivity and unhealthy eating) and tobacco as the key risk factors to target interventions in fiscal years 2010-2011. Staff will continue to work with SHIP staff, LHDs and tribal governments to integrate interventions that will address the needs of pregnant women and secondhand smoke.

In addition, staff will continue the following activities in the coming year: 1) trainings and technical assistance for MDH grantees, LHDs and community-agency staff on implementing the "5 A's" and reducing secondhand smoke exposure, 2) working with the Community Action Team of the American Indian Infant Mortality Review project, and 3) technical assistance and consultation to Twin Cities Healthy Start.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	8	9.8	11	8.5	7.2
Annual Indicator	11.7	8.9	9.7	7.4	
Numerator	44	33	36	27	
Denominator	375522	372719	371683	366844	
Data Source				MN Vital Statistics	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	7.1	7	6.9	6.8	6.8

Notes - 2009
Most recent data available is 2008.

Notes - 2008
2008 Population count not yet available.

Notes - 2007
2007 data not yet available

a. Last Year's Accomplishments
In the fall of 2007 the state Departments of Health (MDH) and Human Services (DHS) agreed to combine funds for suicide prevention. Funding from the SAMHSA Community Mental Health Block Grant was combined with the 2007-2008 state appropriation for suicide prevention. In addition, the CYSHCN program added state funds from its clinic program, providing a combined total of $800,000 for a two year period. An RFP process was completed in the spring of 2008 and MDH awarded five grants for suicide prevention.

Each grantee was awarded $180,000 over a twenty-two month period to engage in evidence-based suicide prevention activities, including public education, gatekeeper training for both youth and adults, community organizing, and culturally specific prevention activities in tribal communities. Grantees engaged in activities to address suicide across the lifespan, including youth and older adults. Program activities began in May, 2008 and ended March 31, 2010.

Staff monitored grant activities, provided training and technical assistance to individuals and organizations throughout the state, and collaborated with other key stakeholders in suicide prevention including the state Departments of Corrections (DOC), Education (MDE) and Human Services (DHS) as well as local nonprofit organizations. Staff participated on the Children's Subcommittee of the State Advisory Council on Mental Health and met regularly with a workgroup on health education facilitated by the department of education.

One of the grantees, Suicide Awareness Voices of Education (SAVE), implemented a statewide public education campaign targeting gatekeepers for four high-risk populations: youth, adult men, older adults, and American Indians. Dissemination of campaign materials took place in early 2009. SAVE also provided training to communities around creating safe and effective public education messages for suicide prevention.

In March of 2009, MDH hosted a daylong workshop with Dr. Teresa LaFromboise as the workshop keynote speaker. She developed the American Indian Life Skills Development Curriculum, which is a culturally specific suicide prevention curriculum. In April 2009, the Title V program submitted a youth suicide prevention grant to SAMHSA (Garrett Lee Smith Act funding), but it was not selected to be funded.

Staff continued to monitor surveillance data and develop expertise in evidence-based strategies. The Title V program also updated its website with current information on suicide and evidence-based strategies for suicide prevention.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Monitor and implement state suicide prevention plan.			X	X
2. Technical assistance to public health and other community agencies				X
3. Participate actively on the Children's Subcommittee of the State Advisory Council on Mental Health				X
4. Continue to support youth activities that support resiliency and healthy behaviors			X	X
5. Continue to analyze student survey data to identify populations at high risk				X
6. Collaborate with public and private partners in suicide prevention			X	X
7. Implement and monitor suicide prevention grants		X	X	X
8. Implement statewide public education campaign for suicide prevention			X	
9.				
10.				

b. Current Activities

Grants funded in 2008 ended in March, 2010. A new RFP was issued in February to distribute the current state allocation for suicide prevention. Three projects were funded to implement evidence-based suicide prevention programs, including public education, training, and school-based

educational programs.

MDH continues to provide technical assistance to individuals and organizations and conduct workshops at relevant meetings and conferences. For example, the Suicide Prevention Coordinator presented a suicide prevention workshop at the Community Health Services Conference in October of 2009 that included information on suicide trends in Minnesota, warning signs and risk and protective factors for suicide, best practices in suicide prevention. Attendees included local public health agencies from the state of Minnesota and other public health professionals.

The Suicide Prevention Coordinator also provided targeted technical assistance to a school district in Minnesota that experienced a significant increase in suicide deaths and attempts in a short period of time. Staff shared information about policies and protocols for school staff, evidence-based curricula for students, and assisted the district in planning a safe and effective response to the crisis.

Staff continues to work with public and private partners in suicide prevention to improve outcomes for youth involved in various systems, including human services, corrections, child welfare and education.

c. Plan for the Coming Year

In the coming year, the Title V program will monitor new suicide prevention grants and will continue to promote the use of evidence-based suicide prevention strategies. Staff will continue to work with public and private partners to coordinate efforts to reduce suicide and improve the mental health of Minnesota's citizens.

The Suicide Prevention Coordinator will provide information and technical assistance on suicide prevention to individuals and organizations throughout Minnesota. As part of this effort, new material will be produced for the suicide prevention web site that was redesigned in 2009. Staff will also provide training and educational workshops to various audiences throughout the state. Staff will also continue its working relationship with Children's Mental health Services and continue to represent the MDH on the State Council on Mental Health and its Subcommittee on Children's Mental Health.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	82	86	87	84	87
Annual Indicator	84.1	83.2	85.6	85.5	
Numerator	702	674	718	693	
Denominator	835	810	839	811	
Data Source				MN Vital Statistics	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year					

moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	87	88	88	89	89

Notes - 2009
2008 is the most recent data available from MN Vital Statistics.

Notes - 2008
2008 hospital data not available yet.

Notes - 2007
2007 data not yet available

a. Last Year's Accomplishments
In 2008, 85.5 percent of very low birth weight infants (infants weighing 1,500 grams or less) were born in facilities appropriate for high-risk, very low birth weight (VLBW) deliveries. This represents virtually no change from 2007.

The Minnesota Perinatal Organization (MPO), Twin Cities Healthy Start, the Minnesota March of Dimes, and the Minnesota Premature Infant Health Network are examples of organizations focusing on healthy pregnancy outcomes. Title V staff worked with all four organizations on a variety of activities including conference planning for professionals, providing technical assistance and training to service providers, policy development and implementation, and role and resource definitions.

Title V staff, the March of Dimes, health plans and hospital systems, nursing education, local public health leaders, and the University of Minnesota's School of Public Health's MCH Epidemiology Program collaborated on Minnesota's second preconception care conference, held November 2008. The conference, "Reaching Underserved Populations," focused on promoting preconception health and providing care to diverse populations experiencing disparities. A focus on preconception and inter-conception health care is viewed by Title V staff as a comprehensive strategy with some potential for prevention of VLBW births overall. The conference had 138 participants and received excellent evaluations. A panel of local experts providing advice on implementing preconception care was especially well received. Planning for the third preconception care conference for fall 2009 began in early 2009.

Title V staff provided technical assistance and consultation to Twin Cities Healthy Start, an agency working with women at high risk for delivering VLBW babies. Pregnant women are assessed for risk factors using a web-based assessment tool called the Pregnancy Risk Overview (PRO) and are enrolled in prenatal care at the appropriate level for their risk of VLBW. They are followed closely throughout pregnancy to assure their social risk factors are addressed and to assure they get the medical care they need to improve their birth outcomes. This includes delivery at a Level III hospital.

Title V staff also participated in biannual Maternity Case Management Excellence regional meetings. These meetings are hosted by the Minneapolis Department of Health and Family Support and include clinic nurses, case managers, community health workers, outreach workers, doulas, public health nurses, social workers, and child birth educators. The purpose of the meetings is to share resources, promote collaboration, discuss barriers and current trends, and to promote and improve coordination of care for high risk pregnant women. There is emphasis on promoting culturally sensitive care and raising awareness of cultural issues that impact pregnancies and births.

MDH staff are part of the Preemie Network hosted by Children's Hospitals and Clinics of Minnesota. Staff participated on a subcommittee to explore using community health workers

(under the supervision of a public health or home care nurse) to provide follow up with families of preemies after discharge.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor the status of perinatal centers in Minnesota.				X
2. Collaborate with external partners such as the March of Dimes, Twin Cities Healthy Start, and the MN Perinatal Organization.			X	X
3. Promote guidelines for Perinatal Care.				X
4. Monitor the number and place of birth for high-risk deliveries.			X	X
5. Actively participate in maternal case management collaborative meetings to improve maternity and infant care for diverse and low-income families.		X		X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The third annual preconception conference, "Achieving Preconception Health: Optimizing Family and Physical Environments" was held October 2009. The conference was broadcast by videoconference to 194 participants at16 sites. Presentations were on fathers and preconception health, environmental exposures, and complementary and alternative therapies and preconception health. Additional resources were posted on the planners' respective web sites with the archived video conference. The conference planners also wrote an article for "Minnesota Physician" published just before the conference entitled Giving Everyone a Healthy Start with the purpose of reaching women's and reproductive health care clinical providers with guidelines for pre- and interconception health care.

The October 2010 preconception conference will be a series of three 90 minute webinars focusing on the social determinants of health, how to address institutional racism and improve cultural competence when delivering services, and the impact of obesity on health.

Staff will attend the annual Office of Rural Health and Primary Care Conference in June 2010 and host an exhibit table of current perinatal data and describing opportunities for improvement in birth outcomes in greater Minnesota.

Staff continue to monitor births of VLBW infants according to "Guidelines for Perinatal Care" published by the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG).

c. Plan for the Coming Year

Minnesota does not have Level III obstetrical and neonatal intensive care available throughout the state. However, providers have affiliations with Level III hospitals for consultation and referral when indicators arise during pregnancy. In some cases these affiliations may be in another state and require patients to travel long distances for appropriate care. Title V staff, in partnership with the March of Dimes, continue to approach this issue by educating providers and patients about risk factors for preterm low birth weight births and appropriate preventive measures.

Title V staff, others at MDH, and community partners will continue the activities stated above and

explore opportunities to educate providers about the importance of high-risk deliveries occurring at an appropriate level facility.

Title V staff will meet with Office of Rural Health and Primary Care staff at MDH to discuss partnering on activities to improve the percent of VLBW deliveries occurring at Level III hospitals.

Title V staff will continue to meet with the Preemie Network to address reducing preterm births and improving preemie outcomes. In addition, MDH in collaboration with partners, will continue to monitor the status of perinatal centers in Minnesota and the number and place of high-risk births. MDH staff and partners will also continue to promote the AAP/ACOG guidelines among providers.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90.5	88	88	87	87
Annual Indicator	86.2	86.5	85.8	85.6	86.1
Numerator	58125	59928	60085	60180	60500
Denominator	67410	69281	70020	70268	70300
Data Source				MN Vital Statistics	Estimates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	88	88	89	89	90

Notes - 2009
2008 is most recent specific data available from MN Vital Statistics. Data listed for 2009 are general estimates based on overall MN trends.

Notes - 2008
2008 natality data not yet available.

Notes - 2007
2007 data not yet available

a. Last Year's Accomplishments
In 2008, 85.6 percent of infants were born to women receiving care beginning in the first trimester. Minnesota has not achieved the Healthy People 2010 goal that 90 percent of births will occur to women who began prenatal care in the first trimester. In Minnesota, women of color and American Indian women have rates farther below the Healthy People 2010 goal and lower than that of White women.

Work continued with local health departments (LHD), representatives of health plans and local providers to create a comprehensive, population-based model of prenatal care. Within this model, early identification of pregnancy, pregnancy intent and early initiation of prenatal care is emphasized. Examples of initiatives to improve the number of women who initiate early prenatal

care include the Twin Cities Healthy Start Program, the Nurse-Family Partnership initiatives in several Minnesota counties, and the Multi-Cultural Maternity Excellence (MCME) project in Minneapolis and St. Paul.

MCME meets semi-annually for education, resource sharing, and networking among providers, health plans and Title V staff. Activities for the past year included identifying gaps in services, implementing improvements and evaluating their effectiveness. MCME has created partnerships for service delivery as exemplified by the Perinatal Services Grid. This grid was created by the health plans to simplify service delivery for provider agencies. Health plans provided financial incentives to low income women on Medicaid to access prenatal care in the first trimester and keep all scheduled appointments.

Twin Cities Healthy Start provided early identification of pregnancy, risk assessment, wrap-around support and education to high risk African American and American Indian women. They serve families until the infant is two years old, thereby providing interconception care and education about early prenatal care for the next pregnancy.

LHDs, with Title V support, promoted the initiation of prenatal care in the first trimester. Some LHDs provided free pregnancy testing with referrals for appropriate services.

The Positive Alternatives grant program continued funding for grantee organizations that encourage and support women in carrying their pregnancies to term by providing a variety of services. Among these services is the requirement that all grantees provide information on, referral to, and assistance with, accessing medical care. This includes encouraging and facilitating early access to prenatal care through early pregnancy testing, assistance in enrolling in state-funded medical programs, and prompt access to medical care.

The second annual preconception conference held in November 2008 focused on reaching underserved populations. The conference had 138 participants from across the state and had several breakout sessions on culturally specific strategies to reach women of color, immigrants and American Indians with education and interventions designed to assure all women are healthy throughout their reproductive years and plan for pregnancy. The need for early and adequate prenatal care for all populations was emphasized.

Minnesota PRAMS data (2006-2007) has identified women's barriers to obtaining early prenatal care. For all women surveyed, 8.1 percent could not get an appointment when they wanted; 7.7 percent did not have enough money or insurance for prenatal care; 5.5 percent said their clinic would not start care as early as they wanted; 5.9 percent did not have a Medicaid card; 5.0 percent had too many other things going on. For women who received late or no prenatal care, 12.1 percent could not get an appointment when they wanted; 20.2 percent did not have enough money or insurance for prenatal care; 7.0 percent had no transportation; 5.5 percent could not take time off work; 9.2 percent said their clinic would not start care as early as they wanted; 13.4 percent did not have a Medicaid card; 6.9 percent had no child care; 11.2 percent had too many other things going on; 11.4 percent did not want anyone to know they were pregnant.

For both populations, the percent of women stating they did not have enough money or insurance has increased significantly since 2004 PRAMS data was collected. This has occurred even though Minnesota's eligibility requirements for Medicaid for pregnant women have remained the same throughout this time period (275 percent of the federal poverty level and without asset limitations).

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support activities that focus on primary health care, family				X

planning, and medical homes for women.				
2. Continue involvement on the Healthy Start grant.		X	X	
3. Partner with racial and ethnic communities to identify and implement strategies for improving early prenatal care.		X		
4. Continue partnerships related to community health worker Program.		X		X
5. Improve statewide universal and system capacity to provide perinatal mental health care.				X
6. Continue TA to OMMH and their grantees on reducing infant mortality.		X		X
7. Sponsor Preconception Conference.				X
8.				
9.				
10.				

b. Current Activities

Outreach activities are fundamental to increasing the number of women who begin early prenatal care. LHDs maintain collaborative relationships with community organizations working with women of childbearing age.

Title V staff consults with Twin Cities Healthy Start and serves on the executive committee. The program focuses on improving rates of early and adequate prenatal care within high risk populations.

Title V staff is presenting adequacy of prenatal care data to rural health agencies including nurses and clinical providers in rural hospitals and to colleagues in MDH's Office of Rural Health and Primary Care. Title V staff will attend the annual Rural Health conference in June 2010 to exhibit a presentation on improving birth outcomes in greater Minnesota; including strategies to encourage early and regular prenatal care.

The third annual preconception conference was held in October 2009 reaching 194 participants via a statewide videoconference. Presentations on preconception and inter-conception health focused on the role of men and fathers, environmental impacts, and complimentary and alternative therapies in care. As women and their families better understand the importance and the components of pre and inter-conception health, it is expected that a continuum of prenatal care will evolve as part of a women's health improvement model.

c. Plan for the Coming Year

Work will continue to address overarching issues leading to delays in prenatal care including pregnancy intendedness, family planning, preconception care, primary health care and establishing a health care home. MDH will work collaboratively with communities to promote culturally appropriate education and awareness regarding the importance of early prenatal care and to address disparities in accessing early prenatal services.

Planning for the fourth annual preconception conference is currently underway and tentatively scheduled for October 2010. Proposed topics for a three session webinar series are: 1) impacts of institutional racism, 2) social determinants, and 3) obesity on pre- and interconception health.

Minnesota's Populations of Color Health Status Report will be updated in 2010 by the MDH Center for Health Statistics. Race, ethnicity and age data will be included. The report will include a section on trends in birth outcomes including adequacy of prenatal care by race, ethnicity, age of mother and insurance status. Use of this report will assure that specific strategies can be developed to get messages to those segments of the public most in need. Title V staff will also continue to review PRAMS data on barriers to accessing early prenatal care to further guide the

strategies.

Title V staff will continue to work with Twin Cities Healthy Start on strategies to promote early and adequate prenatal care within their program.

D. State Performance Measures

State Performance Measure 1: *Proportion of counties that universally offer the Follow-Along Program, or an equivalent approved tracking program, to all children birth to age three.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		53	65	0.7	0.8
Annual Indicator	0.5	0.6	0.6	0.6	0.8
Numerator	46	55	52	55	67
Denominator	87	87	87	87	87
Data Source				Follow - Along Program	Follow-Along Program
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	0.8	0.8	0.8	0.8	

Notes - 2008
Data souce: FAP Data Download from the local agencies: status as of 12/31/2008

a. Last Year's Accomplishments
The MCYSHN program has an interagency agreement with the Minnesota Department of Education for child find or outreach activities. These are activities pursuant to relevant provisions in Part C of the federal Individuals with Disabilities in Education Act (IDEA). This overall function is now known as "Help Me Grow" in Minnesota. Some of these responsibilities are carried out through the Follow Along Program (FAP). The FAP provides periodic screening and monitoring of infants and toddlers at risk for health and developmental problems. It improves chances of identifying developmental problems at an early age, facilitates early intervention services for the child and links families and children to needed services. The FAP is supported programmatically and is funded through Title V and Part C of IDEA at the state level. It is funded at the local level through a combination of Part C, Title V and local funds at the local level.

The Ages and Stages Questionnaire (ASQ) is the screening tool utilized by the FAP. The Ages and Stages Questionnaire -- Social Emotional (ASQ-SE) has been added to screening activities at local agency discretion over the last five years. Ongoing training is provided to local agencies (primarily local public health agencies) on administration of and implementation of the FAP.

Currently, 67 of Minnesota's 87 counties offer the Follow-Along Program without regard to the presence of risk factors known to adversely effect development. There has been a steady increase from the original 24 offering universal screening in 2004. Only three counties do not provide FAP services to families of young children. Twenty-seven percent of the counties serve more than one third of their birth to three cohort; twelve percent serve over half of the families of children under the age of three years in their communities.

Local agencies continue to expand the FAP by increasing the number of children screened for social-emotional or behavioral issues. Most of the children identified through the social emotional

screening stay within local public health agencies, usually in the home visiting program, as these families need parental support rather than direct "mental health" services. Most are very young and have not yet started to display the severe behavioral symptoms of the older children.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. . Provide technical support to local public health agencies participating in the program				X
2. Support advisory group to guide implementation of program enhancements				X
3. Integrate social emotional component into all screening programs			X	X
4. Convene regional FAP Coordinators Meetings				X
5. Analyze program data & disseminate written report			X	X
6. Provide statewide training on reimbursement and funding sources, effective screening, assessment and intervention			X	X
7. Train professionals including FAP coordinators and Human Services professionals on ASQ-SE				X
8. Collaborate and coordinate FAP activities with other state agency initiatives involving social-emotional screening of young children				X
9. Continue developmental and social-emotional screening of children 0-3 as an outcome measure for the Local Public Health Grant Activity.			X	X
10. Support Community Health Board use of federal Title V funds for this activity	X			

b. Current Activities

The MCYSHN program continues to provide technical assistance to local public health agencies through training sessions and software enhancements for the Follow Along Program. Children enrolled in the FAP as of December 31, 2009 totaled 33,338 children (25,448 Birth to 3 and 7,890 3 to 5). The percentage of the birth to three cohort served remained stable compared to 2008 and slightly decreased from 2007.

MCYSHN negotiated with the publishing company of the ASQ questionnaires and was able to secure a discount on behalf of all state and local screening programs and pediatricians in the state who use the newest addition of the ASQ and ASQ/SE as their developmental screening tool. MCYSHN has received American Recovery and Reinvestment Act funds through the Department of Education to adjust the FAP software to accommodate the new ASQ version. In addition, MCYSHN will be exploring the feasibility of an online version on behalf of Help Me Grow (Part C of IDEA).

c. Plan for the Coming Year

This state performance measure will be discontinued due to revised priorities from the 2010 needs assessment. Justification for this revision can be found in the needs assessment document. Despite this revision, activities to address this issue will continue.

State Performance Measure 2: *Percent of children enrolled in Medicaid who receive Early Periodic Screening, Diagnosis, and Treatment (EPSDT), also known as Child & Teen Checkup (CTC) in MN.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		64	65	66	69
Annual Indicator	63.8	63.8	65.5	68.1	69.5
Numerator	161179	161179	165652	176401	190477
Denominator	252584	252584	253051	258938	274047
Data Source				DHS	DHS
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	69	70	70	72	

Notes - 2007
2007 data is not yet available

a. Last Year's Accomplishments
The Title XIX EPSDT program in Minnesota is called Child and Teen Checkups (C&TC). The percent of C&TC eligible infants, children and adolescents who received at least one preventive health visit was 70 percent in 2009 compared with 68.1 percent in 2008.

Under contract with the Department of Human Services (DHS), MDH staff offered an extensive schedule of C&TC trainings on best practices in well child health screening exams to health care providers. Participants included public health nurses, school nurses, private providers, C&TC outreach coordinators, managed care health plan representatives, and other child health screeners. On-site follow-up consultations by MDH staff (pediatric nurse practitioners) were conducted for public health nurses newly trained to provide C&TC screening services.

A new workshop was developed this past year to train providers on best practices during an adolescent screening exam. The training included didactic instruction on best practices in adolescent health, as well as the opportunity for participants to practice psychosocial interviewing skills with trained adolescent actors. The Adolescent Actors Teaching Program at the University of Minnesota were contracted to pilot this interactive training. Additionally, staff provided grand-rounds style training to private primary care providers on implementing developmental and mental health screening into clinical practice.

During C&TC trainings, staff provide information on the Help Me Grow (Minnesota's Early Intervention program) and Minnesota Parents Know website (http://www.parentsknow.state.mn.us/). The Minnesota Parents Know website was developed specifically for parents to provide up-to-date, research-based information on child growth and development from birth through grade 12 and includes an online referral section (Help Me Grow) for parents, providers, and other caregivers to refer children for further evaluation with growth and development concerns.

MCH staff collaborated with DHS and the Women, Infants and Children (WIC) program to develop the 2008 C&TC/WIC family recipe book. The recipe book is currently being used as an outreach tool for families in the WIC program and contains nutritional recipes and developmental milestones, as well as information about both programs. Information regarding the recipe book is also provided in C&TC trainings.

The Interagency Developmental Screening Task Force, which is a partnership between the Title V program, DHS, the Department of Education, University of Minnesota, and the Minnesota Head

Start, continues to provide updates to the statewide recommended pediatric developmental and social-emotional screening instruments list (www.health.state.mn.us/divs/fh/mch/devscrn).

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to provide education, training, and technical assistance on the multiple components of C&TC as a joint activity with DHS.				X
2. Develop, implement and promote quality improvement initiatives for child health in partnership with public and private organizations focused on pediatric health care.			X	X
3. Maintain and enhance partnerships with other organizations that are working to assure optimal child and adolescent health care.		X	X	X
4. Assess the needs of public and private providers of C&TC screening services and provide training, education, and technical assistance around identified needs.		X	X	X
5. Promote evidence-based best practices in child and adolescent health care.		X	X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

MCH staff continue to collaborate with DHS on the C&TC program and provide training to C&TC providers to increase participation and training on preventive health services.

Staff partnered with the MN Chapter of AAP and DHS to begin the implementation the MN Child Health Improvement Partnership's second quality improvement project (Communities Coordinating for Healthy Development). The purpose of this project is to improve linkages between primary care providers, medical specialists, and other child and family service providers to support the healthy development of Minnesota's children ages birth through 3 years.

Through a partnership with Gillette Children's Specialty Healthcare, Shriner's Hospital for Children, and the Twin Cities Spine Center, Title V staff hosted a workshop on recommended screening practices for scoliosis in school-based settings. Participants included PHNs, school nurses, primary care providers, and other screeners. The training was conducted via videoconference to sites throughout the state and allowed participants practice with the screening equipment.

MCH staff have just concluded a pilot project involving eight LHDs to improve lead screening through the use of a brochure targeted to parents. Final results of the project are being compiled.

As part of the Title V Needs Assessment, staff created a fact sheet on comprehensive well baby/child care to provide stakeholders with information on one of Minnesota's priority issues.

c. Plan for the Coming Year

This state performance measure was identified as a priority through the 2010 Needs assessment and will continue to be monitored. Activities will continue as described below.

Staff will continue to review and evaluate current literature as well as information in respected publications such as Bright Futures to develop recommendations for health supervision of infants, children, and adolescents that reflect current evidenced-based practice.

Title V staff serve on the MnCHIP advisory group and will continue to provide technical assistance and consultation to C&TC providers as needed on the Communities Coordinating for Healthy Development quality improvement project.

Staff continue to revise the online C&TC training modules for the following topics: hearing screening, vision screening, developmental and social-emotional screening, oral-dental health screening, lead screening, and introduction to EPSDT.

State Performance Measure 3: *Percent of sexually active ninth grade students who used a condom at last intercourse.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		70	71	71	71
Annual Indicator	69	69	70.8	70.8	70.8
Numerator			5642	5642	5642
Denominator			7971	7971	7971
Data Source				MN Student Survey	MN Student Survey
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	74	74	74	74	

Notes - 2009
The MN Student Survey is conducted every 3 years, and a new one is currently in progress. We will have updated data next year; however this measure is not likely to be carried over.

Notes - 2008
Minnesota Student Survey is data source for this Performance Measure. It is conducted every 3 y ears. Next survey is scheduled for 2010.

a. Last Year's Accomplishments
Minnesota used a total of $10.7 million in state and federal funds to support the Family Planning Special Projects (FPSP) grant program over two years beginning July 1, 2009. These grants were awarded to twenty five agencies representing all regions of the state. This money provides financial support for all method services (including condoms), as well as outreach and education to community groups and juvenile detention sites. Local health departments (LHD) continue to use federal Title V funds to provide family planning method services, reproductive counseling services, and health education in schools.

One of those grantees is a family planning and sexually transmitted infection hotline. The hotline is staffed by individuals trained in information and referral as well as family planning and STI counseling. Over 2,300 calls were handled by the hotline from July 2008 through June 30, 2009. Thirty-five percent (9,961) of the clients receiving counseling services through FPSP and thirty-six percent (8,091) of the clients receiving family planning methods were 14-19 years of age. There were 1,588 male clients receiving family planning methods through FPSP.

The Medicaid 1115 Waiver program, Minnesota Family Planning Program (MFPP) completed its

third year. It had around 19,000 enrollees in September 2009. Under MFPP, adolescents (15 years of age and above) are eligible for family planning services, including condoms.

The Minnesota Education Now and Babies Later (MNENABL) program funded a service-learning training for professionals implementing the Teen Outreach Program (TOP) in order to enhance their current programming. This was done in collaboration with the Minnesota Organization on Adolescent Pregnancy Prevention and Parenting (MOAPPP). In 2008 the state legislature eliminated MNENABL grant funding. However, funding was retained to support a .5 FTE adolescent health coordinator. The adolescent health coordinator was trained as a TOP trainer, one of the first groups of certified trainers outside of the Wyman Center in St Louis, MO to participate in the program's replication.

The Title V Adolescent Health Coordinator worked with the Minnesota Department of Education and the MOAPPP to increase collaboration and joint efforts directed at STI/HIV prevention. In particular, they received a small technical assistance grant to scale up the use of evidence-based practice in state and local teen pregnancy prevention efforts by increasing state and local knowledge about use of evidence-based programs and practices. Activities were accomplished by 9/30/09.

The Adolescent Health Coordinator served on the planning committee for the MOAPPP yearly conference (May 2009) which features national experts and two dozen workshops on evidence-based practice.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to support Minnesota Student Survey data collection and analysis.				X
2. Support access to family planning services for sexually active youth.	X	X	X	
3. Increase public understanding of social, economic and public health burdens of unintended pregnancy.			X	X
4. Support school based clinics and advocate for comprehensive sexuality education.	X	X		X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Title V staff continue to support reproductive health services including contraception services and outreach.

As a newly certified TOP trainer, the Adolescent Health Coordinator completed two TOP trainings in Minnesota, and has more scheduled statewide in the near future.

The state Adolescent Health Coordinator is currently writing an Adolescent Sexual Health Data report, due to be published September 2010. These data include many common measures of adolescent sexual health such as teen pregnancy/ birth rates, and STD/HIV rates, as well as sexual activity data from the 2007 Minnesota Student Survey.

The Adolescent Health Coordinator is on the planning committee for the MOAPPP yearly conference (May 2010) which features national experts and two dozen workshops on evidence-based practice.

c. Plan for the Coming Year
This state performance measure will be discontinued due to revised priorities from the 2010 needs assessment. Justification for this revision can be found in the needs assessment document. Despite this revision, activities to address this issue will continue as described below.

The Family Planning Coordinator will continue to provide technical assistance to FPSP grantees through a monthly newsletter and annual site visits. Staff will help promote the 1115 Medicaid waiver and support family planning service providers in using the waiver.

As a TOP trainer, staff will continue to train professionals in TOP and assist in technical assistance in collaboration with MOAPPP. Staff will continue to work collaboratively with others within and outside the MDH to help address the sexual health needs of adolescents.

State Performance Measure 4: *Incidence of determined cases of child maltreatment by persons responsible for a child's care.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		6.1	6	5	4.5
Annual Indicator	6.2	5.4	4.9	4.3	
Numerator	7983	6998	6227	5404	
Denominator	1286894	1286594	1259456	1258163	
Data Source				MN Dept of Human Services	
Is the Data Provisional or Final?				Final	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	4.5	4	4	4	

Notes - 2009
2009 data not available from DHS and will not be for another year.

Notes - 2008
2008 data not yet available.

Notes - 2007
2007 data not yet available

a. Last Year's Accomplishments
Child maltreatment determination by a person responsible for a child's care decreased from 4.9 incidents per 1,000 children 17 years and younger in 2007 to 4.1 incidents per 1,000 children 17 years and younger in 2008. Counties may use the Family Assessment, a strengths-based and family focused alternative to working with families in the child protection system, when no determination of maltreatment is made.

Minnesota state legislature allocates Temporary Assistance for Needy Families (TANF) funding to local health departments (LHD) and tribal governments to support home visiting services for families with identified risk factors, including risk for child maltreatment. The MCH program administers this program. The MDH FHV Steering Committee and the Training, and Evaluation

Work Groups advise on the implementation of the FHV statute.

In April 2009, FHV staff partnered with Prevent Child Abuse Minnesota (PCAMN) to plan and co-sponsor PCAMN's annual conference The conference provided professionals, community and parent leaders tools for strengthening families and implementing prevention activities throughout Minnesota.

Staff participated on the Minnesota Department of Human Services' (DHS) Child Mortality Review Panel. The state panel reviews clusters of similar deaths of children who are know to the child protection system and makes recommendations for systems changes to protect children.

Four NCAST Parent Child Interaction (PCI) trainings were sponsored in 2008 and FHV consultants supported the use of the PCI tools by trained local and tribal public health nurses to assess parent child interaction and promote the positive attachment of young children. Two Motivational Interviewing (MI) trainings were sponsored in spring 2009. Fifty PHNs were trained on basic principles of MI. MI skills allow home visitors to effectively engage families to promote behavior change.

In 2008, a FHV consultant was trained on the Nurse-Family Partnership (NFP) home visiting model. One of the goals of the NFP model is to improve child health and development and reduce child maltreatment by helping parents provide responsible and competent care. Minnesota currently has five NFP projects covering 17 Minnesota counties.

The FHV team received an Administration for Children and Families (ACF) grant to support evidence-based home visiting to prevent child maltreatment. The goal of the grant is to enhance, expand and sustain evidence-based home visiting programs by supporting infrastructure development and the implementation of the NFP model among replication sites and with population groups experiencing health disparities in the area of child maltreatment. In collaboration with the MDH Office of Minority and Multicultural Health (OMMH), a number of meetings were held with Tribal health directors that expressed interest in looking into the feasibility of adapting and implementing the NFP model for home visiting on tribal reservations.

Minnesota continued the "Safe and Asleep in a Crib of their Own" campaign in partnership with the Minnesota SID Center. Posters, flyers and brochures consistent with the American Academy of Pediatrics infant sleep guidelines were disseminated to LHD, tribal health, community organizations, child care providers, hospitals and clinics. The brochure is available in English, Spanish, Hmong and Somali.

The MDH and the SID Center staff presented "Safe and Asleep" information at conferences. An American Indian work group on SIDS and safe sleep met monthly to develop and implement strategies to effectively reach this population. SIDS and sleep related issues are the leading causes of American Indian infant death in Minnesota. Trainings were also conducted with doulas, community health workers, Positive Alternative grantees, Twin Cities Healthy Start staff, and state grantees working with Somali and other African immigrant populations on eliminating disparities in infant mortality.

Minnesota legislation to reduce the incidence of abusive head trauma to infants (Shaken Baby Syndrome) requires birthing hospitals to educate parents of newborns on definitions and prevention strategies before the baby leaves the hospital. To enhance this parent education, MCH staff distributed "Babies Cry" cards to LHD, tribal health, and community agencies with a suggested parent education protocol to further remind parents and caregivers how to safely manage inconsolable crying of infants.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Identify and participate in opportunities to provide surveillance, identify and disseminate best practices and develop policies to reduce maltreatment.				X
2. Continue involvement Child Death Review Panels.				X
3. Develop/update and distribute Infant Death Investigation Guidelines.			X	X
4. Disseminate strategies for prevention of child maltreatment i.e., home visiting.		X		X
5. Continue to provide NCAST training.			X	X
6. Continue to educate parents and other caregivers on prevention of abusive head trauma (Shaken Baby Syndrome).				X
7. Continue to promote education of parents and other caregivers on Safe Infant Sleep.			X	
8.				
9.				
10.				

b. Current Activities

FHV staff provide support for best practices to serve at risk pregnant and parenting families. Four NCAST PCI trainings were sponsored in 2009. FHV staff support the use of the PCI tools to assess parent child interaction and promote the positive attachment.

The FHV team is implementing year two of the ACF grant. FHV staff provide consultation on implementing the NFP model and other evidence-based practices to LHD and tribal governments.

The FHV Evaluation Plan identifies measurable outcomes for the FHV program, including an indicator on the incidence of child maltreatment. In families being served by home visiting, the rate of child maltreatment was 2.5 percent. This is half that of the NIS-4 rate (five percent) for low-income populations.

Dissemination of "Safe and Asleep" materials and presentations continue with Positive Alternatives grantees. MCH staff provide ongoing support and consultation to the Twin Cities Healthy Start safe infant sleep project with culturally specific materials addressing the higher rates of sleep-related deaths and SIDS among African American and American Indian infants.

In March 2010 the American Indian Infant Mortality conference provided presentations on the outcomes of the American Indian Infant Mortality Review Project and on specific plans and curricula to address prevention of American Indian infant deaths by implementing culturally specific strategies including the development of an adaptation of NFP in tribal communities.

c. Plan for the Coming Year

This state performance measure was identified as a priority through the 2010 Needs assessment. The measure will be modified and continue to be monitored. Explanation of the modifications can be found in the needs assessment document. Activities will continue as described below.

The MDH will maintain a partnership with the SID Center to reduce infant mortality. The SID Center provides grief support to families and providers and risk reduction interventions education. The SID Center maintains communication with coroners and medical examiners and encourages use of MN Infant Death Investigation Guidelines to improve diagnosis of sudden unexpected infant deaths.

FHV will continue to coordinate NCAST PCI trainings and support the use of the PCI scales by

county and tribal public health nurses. Title V staff will continue to participate on the DHS Child Mortality Review Panel. The panel reviews clusters of similar deaths and makes recommendations for systems changes.

FHV staff will implement the FHV training and evaluation plans and provide support to family health supervisors and MCH and home visiting staff in LHD and tribal governments. Training will include home visiting, reflective supervision, motivational interviewing, relationship-based practice, and comprehensive assessment. The FHV website will be maintained and updated with training resources, home visiting strategies and best practices, home safety resources, shaken baby syndrome prevention materials, infant sleep safety and postpartum depression educational materials, and home visiting guidelines.

Staff will continue to promote the infant abusive head trauma prevention and the "Safe and Asleep" campaign. Safe infant sleep has been identified as a key activity to reduce the infant mortality racial and ethnic disparity experienced by African American and American Indian families.

Information and materials will be distributed regarding "The Happiest Baby" educator certificate program. It is anticipated that each LHD and tribal agency will have one certified educator and information will be provide on home visits or group sessions regarding how to calm a crying infant. This will support local efforts to prevent Shaken Baby Syndrome.

The Patient Protection and Affordable Care Act became law adding a new Section 511 to the Title V of the Social Security Act for Early Childhood Home Visiting Programs. States will be required, as a condition of receiving the Title V MCH Block Grant funds for FY2011, to conduct a home visiting needs assessment to identify communities that are at risk for poor maternal and child outcomes and have few quality home visiting programs. The MDH will take the lead on the statewide needs assessment in collaboration with the Minnesota Departments of Human Services and Education. The MDH has created a web page to provide information to local public health agencies and partners as more information becomes available on how the federal funding will be allocated.

State Performance Measure 5: *Percent of pregnancies that are intended.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		70	71	65	66
Annual Indicator	66.3	64.0	63.7	63.3	
Numerator	44408	43882	44066	42714	
Denominator	67017	68538	69230	67496	
Data Source				MN PRAMS survey	
Is the Data Provisional or Final?				Final	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	66	67	67	67	

Notes - 2009
2009 PRAMS data not available untill next year.

Notes - 2008
2008 PRAMS data not yet available.

Notes - 2007

2007 data not yet available

a. Last Year's Accomplishments

According to the Minnesota Pregnancy Risk Assessment Monitoring System (PRAMS) survey done with 1,494 Minnesota mothers who had a baby in 2008, the percent of intended pregnancies resulting in a live birth in Minnesota (63.3 percent) has remained essentially the same since 2004. The data are more concerning when looking at pregnancy intendedness for specific demographic groups. In 2008, 72.7 percent of mothers age 35+ intended pregnancy, while only 19.1 percent of mothers less than age 20 and less than half (45.4 percent) of 20-24 year olds intended pregnancy. Of mothers with a college education, 78.5 percent intended pregnancy, but just 45.3 percent of mothers with a less than high school education and 53.1 percent of mothers with a high school education intended pregnancy. Intention was very different by mother's race. Among White mothers, 67.3 percent reported the pregnancies were intended, whereas 53.0 percent of Black mothers and 36.8 percent of American Indian mothers reported their pregnancies were intended. Pregnancy intention also varied greatly by household income. While 37.0 percent of mothers with incomes below $14,999 intended pregnancy, 80.2 percent of mothers within income above $50,000 intended pregnancy.

Minnesota uses state general funds and federal Temporary Assistance for Needy Families (TANF) funding to support Family Planning Special Projects (FPSP) grants. FPSP funds are used by local communities to provide method services, as well as outreach and education to those at risk for unintended pregnancy. Local health departments (LHD) use their allocation of federal Title V funds to provide family planning method services, reproductive counseling services, and health education in schools.

A total of $10.7 million dollars in FPSP grants were awarded over two years beginning July 1, 2009 to 25 agencies representing all regions of the state. FPSP funds also support a family planning and STI hotline. $1.15 million per year of this total is TANF fund.

The Medicaid 1115 Waiver program, Minnesota Family Planning Program (MFPP), completed its third year. It had approximately 19,000 enrollees in September 2009.

MDH staff served on the planning committee for the annual Reproductive Health Conference held in September 2009.

There were 138 attendees at the second annual Preconception Care Conference in November 2008 who heard both national and local speakers discuss specific issues and strategies addressing preconception care for underserved populations. The conference was well received according to evaluation data. Evaluations specifically sighted a panel of local experts who made brief presentations and took questions from the audience with practical advice on implementing preconception care within their existing programs as an important component of the conference. Breakout session topics included reaching African American, Somali, American Indian and Hmong women and women in rural Minnesota. A viewing and discussion of "When the Bough Breaks" was also one of the breakout sessions.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Analyze PRAMS data.				X
2. Ensure efficient and effective use of state funds for family planning services.	X	X	X	
3. Partner with Department of Human Services to successfully implement 1115 Family Planning Waiver.			X	X
4. Increase public understanding and support for policies &			X	X

programs that reduce unintended pregnancies.				
5. Consider policy and program recommendations for prenatal, interconception care and child spacing.			X	X
6. Continue to direct resources to a hotline for family planning and STI services.			X	X
7. Support school-based clinics and comprehensive reproductive health education.			X	X
8.				
9.				
10.				

b. Current Activities

The Family Planning Coordinator is conducting site visits with all 25 grantees to monitor grantee progress in achieving goals and to provide technical assistance. A monthly electronic newsletter is sent of trainings and the latest research on family planning. The Family Planning Coordinator serves on the planning committee for the annual Reproductive Health Conference. MDH continues to work with the Minnesota Department of Human Services to promote MFPP and assist FPSP grantees in implementation of MFPP in their clinics.

The 3rd annual preconception conference was held in October 2009 by videoconference at 16 sites with 194 people attending. The conference, Achieving Preconception Health: Optimizing Family and Physical Environments, focused on fathers and preconception health, preconception environmental exposure, and alternative therapies and preconception health. Resources were posted on the conference planners' web sites with the archived video conference. The conference planners also wrote an article for "Minnesota Physician" published in September 2009, Giving Everyone a Healthy Start, with the purpose of reaching women's and reproductive health care clinical providers with guidelines for pre and inter-conception health care.

PRAMS, BRFSS, Minnesota Student Survey and abortion report data continues to be analyzed to provide information on possible strategies for improving pregnancy intendedness.

c. Plan for the Coming Year

This state performance measure will be discontinued due to revised priorities from the 2010 needs assessment. Justification for this revision can be found in the needs assessment document. Despite this revision, activities to address this issue will continue as described below.

The Famly Planning Coordinator will continue to provide technical assistance to FPSP grantees through a monthly newsletter and annual site visits. Staff will continue to help promote MFPP and support family planning service providers in implementing MFPP. By June 2011, a determination will be made on if to extend the current FPSP grant or issue a new request for proposals.

The preconception conference planning team for 2010 includes representatives from local public health, the March of Dimes, the University of Minnesota School of Public Health MCH Program, health plans and hospital systems, nursing education, Twin Cities Healthy Start, and Title V staff. This year's conference (October 2010) will be a series of three 90 minute webinars focusing on the social determinants of pre and inter-conception health, how to address institutional racism and improve cultural competence when delivering pre and inter-conception health services, and the impact of obesity on pre and inter-conception health.

Title V staff will continue to monitor PRAMS data on pregnancy intendedness and use this information to inform program and policy decisions.

State Performance Measure 6: *Percent of pregnant women screened for depression during routine prenatal care.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		83	84	86	86
Annual Indicator	85.4	85.6	88.9	89.9	
Numerator	56690	59389	61744	61028	
Denominator	66396	69413	69422	67889	
Data Source				MN PRAMS survey	
Is the Data Provisional or Final?				Final	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	87	88	88	88	

Notes - 2009
2009 PRAMS data not available from CDC yet.

Notes - 2008
2008 PRAMS data not yet available.

Notes - 2007
2007 data not yet available

a. Last Year's Accomplishments
Postpartum depression education legislation passed in 2005 requires that hospitals, physicians and other professionals providing prenatal care and/or delivery services provide new parents and other family members written information about postpartum depression (Minnesota Statute.145.906).

Materials which include a brochure and fact sheet continue to be available for download on the MDH web site. These materials are available in multiple languages including Spanish, Hmong, Somali and Russian. The materials include the information about postpartum depression required by the legislation These materials are available on the MDH website at: http://www.health.state.mn.us/divs/fh/mch/fhv/strategies/ppd/index.html The MDH also provides technical assistance and review of materials developed by hospitals and other health care providers to assure all such materials comply with the educational requirements specified in the legislation.

Multiple presentations, exhibits and materials were provided on maternal mental health and postpartum depression in a variety of venues. Examples include statewide conferences, workshops and community events, such as the National Alliance for the Mentally Ill-Minnesota (NAMI-Minnesota) conference and Healthy Development Conference.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote maternal depression screening by providers during routine prenatal and postpartum visits as well as during pediatric and well child visits.			X	
2. Update/translate (as needed) and disseminate maternal depression education materials to prenatal, hospital, postpartum,		X		

and pediatric/well child practitioners.				
3. Provide technical assistance and educational opportunities for county and tribal health staff on maternal mental health promotion, risk/protective factors, screening and referral, and issues related to working with women with mental illness.				X
4. Provide education through appropriate media to health consumers and the public on maternal mental health and the importance to the health and well being of the mother and her family.		X		
5. Provide leadership and collaborate with other state agencies and providers, health plans, and others regarding the need to address appropriate mental health services for prenatal and postpartum depression.				X
6. Promote awareness of and monitor reimbursement for prenatal and postpartum depression screening by the Department of Human Services and Minnesota Health plans.				X
7.				
8.				
9.				
10.				

b. Current Activities
The MDH postpartum depression resource page was updated. Planning for a 2010 NAMI-Minnesota conference on postpartum depression is underway.

The Great Start Minnesota project promotes screening for maternal depression in pediatric clinic settings. Effective January 1, 2010, the Minnesota Health Care Program (MHCP) began providing reimbursement for maternal depression screening as a separate service when performed during a C&TC or other pediatric visit. The Department of Human Services also encouraged providers to provide depression screening for mothers of MCHP-eligible children under age one.

New family home visitor training includes a unit on postpartum depression and the importance of regular and routine screening. This training is scheduled to be launched in early 2010 with additional training being held in the fall of 2010.

The MDH remains an active partner in Pregnancy and Postpartum Support Minnesota (PPSM), Minnesota's Postpartum Support International. PPSM maintains a provider resource listing for the metropolitan area and conducts a range of public awareness activities. A link to the PPSM web site is included on the MDH web and on the MDH postpartum depression brochures and fact sheets. The MDH has also begun collaborating with Hennepin Women's Health Program to promote awareness of their web based provider education service and resource directory. This program operates through the Hennepin County Medical Center and includes resources throughout the state.

c. Plan for the Coming Year
This state performance measure will be discontinued due to revised priorities from the 2010 needs assessment. Justification for this revision can be found in the needs assessment document. Despite this revision, activities to address this issue will continue as described below.

Analysis of Minnesota's PRAMS data on postpartum depression will continue. Data continue to be analyzed and shared to raise awareness of the need to screen for perinatal depression. Data from the revised PRAMS questionnaire will be available in 2011.

The MDH will continue to work with PPSM on a variety of public awareness activities. Activities

are aimed at increasing public awareness of postpartum depression and to promoting training for mental health practitioners to increase the availability of clinical intervention for postpartum depression and other perinatal mood disorders. Training on postpartum depression screening will be offered for home visitors throughout Minnesota in conjunction with MDH's Comprehensive Assessment training for the Family Home Visiting program.

Information regarding screening for postpartum depression will be routinely provided to pediatric and family practitioners through MDH C&TC three-day and newborn/preemie trainings. Included will be information regarding billing for postpartum depression screening as part of pediatric primary care visits.

MDH staff will continue to monitor funding opportunities to support education for postpartum depression and advance perinatal depression screening and treatment services. During the upcoming year, the MDH will be advancing the availability of culturally responsive postpartum depression educational materials for the American Indian population.

The MDH will continue to provide leadership, technical assistance and training opportunities with community partners, local health department and Tribal health staff, and others regarding the importance of perinatal depression screening and the need to address system issues that limit access to timely and appropriate mental health services for perinatal depression.

State Performance Measure 7: *The degree to which Title V programs enhance statewide capacity for a public health approach to mental health promotion and suicide prevention for children and adolescents.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		2	2	2	3
Annual Indicator	1	1	2	2	2
Numerator	1	1	2	2	2
Denominator	4	4	4	4	4
Data Source				MCSHN	MCSHN
Is the Data Provisional or Final?				Provisional	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	3	4	4	4	

a. Last Year's Accomplishments
Five suicide prevention grants were active during this time period. Four of the grantees included prevention activities targeting children and youth, and the fifth grantee focused on adults over the age of 55. These grants combined funding from a state general fund appropriation for suicide prevention, federal mental health block grant funding and state funds from the MCYSHN program. A limitation on the use of the federal funds is the reason why one of the grantees' target population was adults over 55. The Minnesota Department of Human Services administers the SAMHSA mental health block grant and the decision to combine federal and state funds for suicide prevention and have Title V manage the grants reflects the positive collaborative working relationship between the two programs.

In addition to monitoring grant activities, MDH submitted a grant proposal for the Garrett Lee Smith suicide prevention funding awarded annually by SAMHSA. Minnesota's application was not accepted for funding.

Staff promoted healthy behaviors through support of a public health model of mental health and collaborated with partners to promote mental health and prevent mental illness. In September of 2009, MDH launched new web pages for suicide prevention and mental health promotion. Staff

also participated on the department of human service's State Advisory Council on Mental Health and its Subcommittee on Children's Mental Health. MCYSHN staff also met regularly with other state agencies that address mental health and the social and emotional development of children and youth, including the department of education and the department of corrections.

Staff provides technical assistance to local public health and community organizations on mental health and suicide prevention. This includes surveillance data, information about evidence-based strategies, and resource information. Staff collaborated with the University of Minnesota School of Public Health to help plan its 2009 Summer Institute on Adolescent Health, which focused on social and emotional health. In March, MDH held a one-day training for suicide prevention grantees and representatives from tribal health departments. Dr. Theresa LaFromboise presented a workshop on an evidence-based, culturally-specific prevention curriculum she developed called American Indian Life Skills Development. This curriculum covers a broad range of topics and life skills, including substance use, suicide, coping with trauma, healthy problem-solving and decision-making, and how to help a friend.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Review and update, with key stakeholders, the State Suicide Prevention Plan				X
2. . Continue to provide trainings around suicide prevention and children's mental health issues				X
3. Continue to partner with DHS (mental health authority) related to mental health screening, intervention and treatment				X
4. Design and implement a suicide prevention program in response to state legislation			X	X
5. . Represent MDH on State Advisory Council on Mental Health and children's mental health subcommittees and related mental health workgroups				X
6. Partner with the departments of education and human services on annual statewide mental health conference				X
7. . Administer suicide prevention grants	X			X
8.				
9.				
10.				

b. Current Activities

The grants funded in 2008 ended in March, 2010. A new round of grants funded for the time period June 15, 2010 through December 31, 2011 was established. Three projects were funded to implement evidence-based suicide prevention programs, including public education, training, and school-based educational programs. Staff will continue to manage these grants and provide technical assistance, training and consultation to suicide prevention grantees, as well as technical assistance and consultation to local agencies and organizations including surveillance data, information on evidence-based strategies and resource information.

The Suicide Prevention Coordinator provided targeted technical assistance to a school district in Minnesota that experienced a significant increase in suicide deaths and attempts in a short period of time. Staff shared information about policies and protocols for school staff, evidence-based curricula for students and assisted the district in planning a safe and effective response to the crisis.

Program staff participates on the State Advisory Council on Mental Health and the Subcommittee

on Children's Mental Health. In October, the suicide prevention coordinator presented a workshop on best practices in suicide prevention at the Community health Services Conference--an annual meeting for local public health agencies throughout Minnesota.

c. Plan for the Coming Year
Staff will continue management of the grants awarded for suicide prevention with an increased emphasis on evidence-based mental health promotion and suicide prevention practices. Program staff will continue to provide technical assistance and consultation, surveillance data, and information about resources and best practices to local organizations and the general public. Staff will also continue to meet with other state agencies on a regular basis around children's mental health and suicide prevention, and will continue to be involved with the State Advisory Council on Mental Health and its Subcommittee on Children's Mental Health.

MDH will continue to provide technical assistance to local public health and community organizations on mental health and suicide prevention and staff will continue activities to promote the public health approach to mental health through presentations, technical assistance, and our web site. MDH will work with local public health agencies to: (1) determine the additional capacity and training needs of LPH nurses, health educators and other local staff regarding mental health promotion and suicide prevention; and (2) support development of needed resources and capacity for our LPH constituents statewide.

State Performance Measure 8: *The ratio of the low birth weight (<2500 grams) rate for American Indian women and women of color to the low birth rate for white women.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		1.2	1.2	1.1	1
Annual Indicator	1.4	1.3	1.4	1.4	
Numerator	86	82	8.5	8.4	
Denominator	60.1	61	6.2	5.8	
Data Source				MN Vital Stats	
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	1	1	1	1	

Notes - 2009
2009 data not available yet.

Notes - 2008
2008 natality data not yet availab.e

Notes - 2007
2007 data not yet available

a. Last Year's Accomplishments
MCH staff provided consultation and resources to community-based programs that address racial/ethnic disparities in birth outcomes, including infant mortality and low birth weight (LBW).

The federally funded Twin Cities Healthy Start (TCHS) program provided outreach, case management and health education to African American and American Indian pregnant and parenting families in Minneapolis and St. Paul. The TCHS program focused on reducing

disparities in infant mortality and reducing LBW, especially among African American infants. Low birth weight rates among African American infants are more than twice the rate of White infants (8.7 percent vs. 4.3 percent for the years 2003-2007). TCHS staff attended the smoking cessation in pregnancy training in August 2009 and used the cessation resources available from the MDH. Smoking cessation in pregnancy is a strategy to reduce low birth weight.

MCH staff continued to support Community Health Worker (CHW) education and employment, recognizing that disparities in LBW are related to the availability of culturally competent health care services. Legislation in 2007 allowed for Medicaid reimbursement for CHW services when provided under the supervision of a Medicaid-enrolled provider. CHWs are recognized as valuable community providers who can bridge a gap between health care providers and populations of color. Connecting pregnant women to health care and resources such as the WIC can help reduce LBW.

The second preconception conference was held in November 2008, sponsored by MDH, the March of Dimes, local public health, Twin Cities Healthy Start, the University of Minnesota and health care systems. The focus of the conference was "Reaching Underserved Populations." One session featured a viewing of "When the Bough Breaks" with a facilitated discussion on the impact of LBW and prematurity on African Americans. It was attended by 138 people and received favorable evaluations.

MCH staff provided consultation and resources to programs funded by MDH's Office of Minority and Multicultural (OMMH) Health's Eliminate Health Disparities Initiative. This funding included support for reducing infant mortality and LBW disparities between Whites and populations of color. The programs provided a variety of services including doulas, health education, smoking cessation, child spacing, referral to WIC and support for breastfeeding. All services addressed reducing the disparity in infant mortality and reducing LBW.

Although African/African American women are less likely than White and American Indian women to smoke during pregnancy, they are likely to be exposed to secondhand smoke. Title V staff emphasize the importance of counseling African/African American women to avoid such exposure to help prevent LBW and premature births.

The American Indian Infant Mortality Review Project (conducted in 2007 and reported in 2008) determined that of 24 deaths reviewed, nine babies were born at low birth weight. Although this is not surprising in a population of babies who died, it is a reminder that reducing LBW is also a priority among the American Indian population. This project is in the action and implementation phase with a Community Action Team and three work groups, each focused on a priority recommendation from the report. One of the work groups is addressing institutional racism in the health care system and the impact on early and adequate prenatal care. Another work group is addressing teen pregnancy prevention using culturally specific curricula. Reducing initial and repeat teen pregnancies among American Indians and other populations of color are promising approaches to reducing disparities in low birth weight.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Ongoing collaboration with Twin Cities Healthy Start.		X	X	X
2. Ongoing partnership with MN State Colleges on Community Health Worker education project.		X	X	X
3. Ongoing technical assistance to the Eliminate Health Disparities Initiative, infant mortality grantees.			X	X
4. Continue to dialogue with Tribal Health Leaders around issues related to poor pregnancy outcomes.		X	X	

5. Continue to provide TA to Tribal Governments on Family Home Visiting.			X	X
6. Continue efforts to inform the public of the need to stop smoking and engaging in other high risk activities during pregnancy.			X	X
7.				
8.				
9.				
10.				

b. Current Activities
Staff conducts trainings on implementing the "5 A's" best practice intervention for smoking cessation in pregnancy with Positive Alternative grantees and public health nurses.

Staff is a member of the March of Dimes Program Services Committee and is planning a Grand Rounds presentation for providers on reducing smoking in pregnancy using the 5 A's. The Grand Rounds will be presented by video conference and broadcast to hospitals across the state.

Staff continues to provide technical assistance to assure women receive early and adequate prenatal care, support for smoking cessation, and referrals to the WIC program all as preventive approaches to LBW and prematurity.

The 3rd annual preconception conference was held in October 2009 with 194 participants at 16 videoconference sites. Presentations on preconception and inter-conception health, the role of fathers, environmental impacts, and complimentary and alternative therapies in care.

The OMMH is selecting grantees for a new round of Eliminating Health Disparities Initiative funding, including disparities in infant mortality and LBW. Title V staff participated in development of the request for proposal, grant reviews, and will provide ongoing technical assistance to new grantees.

MDH staff is participating in a LBW project that matches MDH birth certificate data with Department of Human Services Medicaid claims data to determine rates of LBW between those covered by Medicaid and the non-Medicaid covered births.

c. Plan for the Coming Year
This state performance measure will be discontinued due to revised priorities from the 2010 needs assessment. Justification for this revision can be found in the needs assessment document. Despite this revision, activities to address this issue will continue as described below.

Plans are to continue all activities described above. MCH staff will continue to expand and integrate activities with the OMMH activities, especially efforts to eliminate the disparity in infant mortality and low birth weight among populations of color and American Indians.

Planning for the 4th annual preconception conference is currently underway and tentatively scheduled for October 2010. Proposed topics for a three session webinar series are: respective impacts of institutional racism, social determinants, and obesity on pre and inter-conception health.

State Performance Measure 9: *Percent of Children and Youth with Special Health Care Needs (CYSHCN) with one or more unmet needs for specific health care services.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		14.1	10	12	12
Annual Indicator	14.1	12.9	12.9	12.9	12.9
Numerator	21498	22967	22967	22967	22967
Denominator	152468	177669	177669	177669	177669
Data Source				SLAITS	SLAITS
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	11	11	10	10	

Notes - 2008
data source: National Survey of CSHCN 2005 / 06

Notes - 2007
2007 data not yet available

a. Last Year's Accomplishments
This measure specifically addresses access to a medical home, oral health, specialty care and the organization of services.

There is professional consensus that children with a medical home are more likely to have their need for services met across all systems than are children without a medical home. Establishing, spreading and sustaining the concept of medical home in Minnesota is the primary activity used to address this performance measure. 2008 legislation required standards be developed for voluntary certification of primary care practices as health care homes beginning in July of 2009. Development of these standards began in the fall of 2008 with the formation of a unit reporting to the Executive Office but housed with the MCYSHN program. The Title V program assisted this new unit throughout the year through support for a community-wide certification work group and by drafting RFPs to assess the capacity of the primary care system to implement health care homes.

Medical home collaborative learning sessions were held in January and May of 2009 and were done so in conjunction with the EHDI collaborative learning sessions. The MCYSHN program continued to maintain and staff a toll-free phone line giving families and providers access to information regarding services and resources in their communities.

A considerable amount of Title V time was devoted to autism in the Somali community because of a high rate of Somali children in Minneapolis school special education programs. While most of this activity was focused on prevalence and incidence issues, a one-day forum for Somali parents, educators and providers on linking community resources with Somali families was sponsored by Title V. A second forum was held for professionals serving the Somali community and others with autism. One result of the above activity was a decision to initiate learning collaborative on autism and other developmental disabilities. Planning for this new collaborative began in September of 2009

The MCYSHN program continues to partner with the Children's Mental Health Services Division at the Minnesota Department of Human Services (DHS) to provide statewide trainings on the DC: 0-3™ diagnostic criteria as a method to increase local capacity of mental health professionals for service provision to young children. DC: 0-3™ is a taxonomy that allows a more child friendly diagnostic classification system that can be converted to the DSM-IV classification system for purposes of reimbursement thereby decreasing financial barriers to mental health services. To date, 2,500 professionals have been trained in the diagnostic criteria specifically and infant mental health generally.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to provide TA to Medical Home Teams		X		X
2. Continue support of mental health activities and initiatives underway		X		X
3. Continue support of interagency planning at the individual level				X
4. Continue to develop community-based specialty services particularly in the areas of developmental and autism evaluation, and cleft-lip / palate.				X
5. Sponsor specialty healthcare regional conferences				X
6. Continue leadership role in health conditions and early intervention eligibility		X		X
7. Provide outreach to increase awareness of community-based resources among the health provider community		X		X
8. Continue the Take the Maze out of Funding workshops to inform families, community agencies and health care providers of resources available.		X		
9. Assist in the implementation of Health Care Home legislation.	X	X	X	X
10.				

b. Current Activities

The MCSHN Information and Assistance (I and A) program continued to respond calls from families and professionals seeking health care resources for CYSHCN. Efforts focusing on the availability of web-based information continue. A new directory of services was completed early this year. Title V provides technical consultation and assistance to those practices seeking certification as health care homes This will be the final year for the MCYSHN Development/Behavior and Cleft lip/palate clinics.

The collaboratives for EHDI and autism and other developmental disabilities are active. The EHDI collaborative will attempt to enroll additional teams participating in that activity. The autism and other developmental disabilities collaborative has seven community teams participating in that collaborative. The first learning session was held in March; the second in June. MCYSHN submitted a grant application in June for funding to continue this collaborative. MCYSHN is leading the development of a mental health index tool for primary care practices to use as a resource, modeled after the medical home index tool.

Title V works closely with the state's Medicaid program. The Medicaid program has been awarded the ABCD-III grant from the Commonwealth Fund to create more efficient linkages to support healthy child development. Title V will works closely with Title XIX to implement the grant's objectives.

c. Plan for the Coming Year

The above activities will continue. In addition, we will be exploring the potential for disseminating best practices to clinical service providers through webinars and broadcasts.

State Performance Measure 10: *Degree to which comprehensive mental health screening, evaluation, and treatment is provided to Children and Youth with Special Health Care Needs (CYSHCN).*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		7	8	9	12
Annual Indicator	6	7	9	11	15
Numerator	6	7	9	11	15
Denominator	20	20	20	20	20
Data Source				MCSHN staff	MCSHN staff
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	12	13	13	14	

a. Last Year's Accomplishments
This state performance measure examines the state's progress in relation to a mental health system of screening, evaluation and treatment for MCYSHN.

The MCYSHN program worked closely with Children's Mental Health Services (CMHS) of the Minnesota Department of Human Services. CMHS was one of five grantees in the Assuring Better Child Development-III (ABCD-III) grant activity funded by the Commonwealth Fund and administered by the National Association of State Health Policy (NASHP). This project will focus on supporting changes at three different levels: primary care, community child and family service providers, and across statewide systems. The project will assist designated care coordinators in pilot PCP offices to implement referral protocols, incorporate information provided by child and family service providers into clinic workflow, incorporate practices established by the Minnesota Medical Home Project, and co-locate services. At the community level, the project will develop service agreements between child health care providers and other child and family service providers and assist in the development of standard referral, consent and fax-back forms and resource listings. The project will increase awareness and encourage use of Minnesota's statewide Help Me Grow early intervention and referral phone line and the Minnesota ParentsKnow website and online referral request for providers and families.

MCSHN district staff and CMHS regional staff met periodically to discuss issues surrounding service availability and planning within respective regions. Quarterly regional staff meetings include Medicaid Home and Community Based Waivered Services staff, CMHS and MCHSN staff who identify resource issues, gaps in services and develop plans that can be implemented at the regional level to address the availability of appropriately trained and supervised behavioral aides for children and their families. MCYSHN program staff collaborated with the CMHS program through staff support of DC:0-3 trainings.

MCSHN focused its efforts on logistical support of DC: 0-3 trainings, integrating mental health curricula into medical home learning sessions and the operation of Development and Behavior Clinics. These clinics provided a one-day, multidisciplinary team diagnostic assessment of children up to the age of 21. The children referred have multiple behavioral, developmental, educational and physical issues. Most referrals originate from schools districts of less than 2000 total enrollment, most children are five to nine years of age and most have private insurance.

The Minnesota Department of Education (MDE) is the lead state agency for implementation of Part C in Minnesota. Through an interagency agreement, the MCYSHN program is responsible for the child find outreach activities pursuant to Part C requirements. One of the ways this has been fulfilled is through the local Follow Along Program (FAP). The Ages and Stages Questionnaire (ASQ) is the screening tool used by the FAP. Staff provided training and consultation to local agencies on the FAP and administration of the ASQ-SE. Over 600 professionals and paraprofessionals were trained in the administration and scoring of the ASQ and ASQ-SE in this last year. Sixty FAPs have now integrated the Social/Emotional component of the ASQ into their programs.

MCYSHN was on the steering committee for Minnesota Association for Infant and Early Childhood Mental Health (MAIECMH), a consortium of groups that developed standardization and credentialing of infant mental health providers. Staff also provided consultation and technical assistance to the Minnesota Thrive Initiative launched by the six (6) Minnesota Initiative Foundations to help communities support the healthy social and emotional well-being of young children.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue collaboration with Children's Mental Health Services (CMHS) of the Minnesota Department of Human Services.				X
2. Continue logistical support for DC:0-3™ trainings throughout the state				X
3. Continue supporting CMHS in its implementation of the Commonwealth Fund's ABCD-II grant.				X
4. Support regional trainings and workshops				X
5. Continue to promote universal implementation of the ASQ and ASQ-SE.	X		X	
6. Continue to promote interagency coordination of services.				X
7. Continue to conduct MCSHN Development and Behavior Clinics	X			
8. Implement recommendations on autism.				X
9.				
10.				

b. Current Activities

Administrative and training activities continue through the Follow-Along Program, use of the ASQ screening tool and its social-emotional component, the ASQ-SE. The state Medicaid program contracts with the Title V program for CTC (EPSDT) trainings for local public health agencies. These trainings now include training on the ASQ and ASQ-SE. Staff facilitated capacity building around infant and early childhood social-emotional issues.

Funding for the Development and Behavior clinics has been discontinued. MCSHN District Staff are working with providers and families to identify options for children and their families to receive multidisciplinary assessments in or close to their own areas. In several communities where the loss of these multidisciplinary clinic services will have a greater impact, provider/parent groups have developed frameworks for the continuation of multidisciplinary team assessment "clinics" utilizing local resources and providers. Collaboration with CMHS and DC: 0-3 statewide trainings continue, reaching a total of slightly more than 2,500 mental health and early childhood professionals over the last three years.

Title V is utilizing a collaborative learning model to address issues presented by autism. This approach employs learning sessions and partnerships with the state AAP Chapter, the state's LEND grantee, the Governor's Council on Developmental Disabilities and Children's Mental Health Services.

c. Plan for the Coming Year

Collaboration with the Department of Human Services at the state and regional level through the support of CMHS in its ABCD-III activities and administrative support of DC: 0-3 trainings will continue. Trainings are expected to include a repeat of the previous offerings as well as

advanced curricula for individuals who desire a more in-depth knowledge and understanding of interventions to promote the social-emotional health of young children. MCYSHN will work with DHS-CMHS to develop a tracking system of DC:0-3 training attendees. This tracking system will be designed to determine whether providers that see children ages 0-3 utilize the DC:0-3 diagnostic protocol. This information will be distributed to local providers, public health agencies, early intervention committees and others in a position to refer young children and their families for diagnostic assessment.

Local capacity building initiatives such as regional mental health needs assessment and planning, consultation and technical assistance in the area of mental health continue. One example being support planning and implementation of efforts addressing the availability of appropriately trained and supervised behavioral aides for children and their families. MCYSHN district staff will work in collaboration with CMHS regionally assigned staff to promote the development and implementation of models of co-location of health and mental health staff, quality improvement models that include telemedicine or other methods of psychiatric consultation to pediatric and family practice physicians in the far reaches of Greater Minnesota and models of service delivery for young children and their families that promote cross agency collaboration in rural areas where both population and services are sparse. State staff will continue to offer ASQ/ASQ-SE training for early childhood personnel.

E. Health Status Indicators

Introduction

The health status indicators which are addressed and reported in this document contribute to the ability of our state agency to assemble and analyze information pertaining to Minnesota residents. These indicators clarify areas of need as well as areas of achievement, which in turn assist in determining our primary foci. This process has been of distinct benefit this year in preparing our Needs Assessment for 2010-2015.

Data on specific indicators can be viewed independently, as a means to establishing baselines for particular issues, or correlated with other variables such as age, education, poverty status, and race/ethnicity to provide a broader view on a particular topic. Such cross-tabbed analyses not only verify existing patterns but often reveal emerging trends which are of use in community planning, ongoing clinic programs, and other proactive interventions.

Of particular interest and utility is the cross-agency data which we obtain from other departments and agencies throughout the state. These data are also broken down by age, race and ethnicity, providing further insight into areas of greatest need. Data collected by these state agencies combine well with public health statistics and lend greater depth and meaning to our findings.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	6.6	6.6	6.8	6.4	
Numerator	4685	4709	4982	4655	
Denominator	70899	71344	73651	72356	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year,					

and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2009
Our health status indicators, which are processed by the MN Center for Health Statistics, are typically 1 to 1-1/2 years behind any given calendar year. Thus, 2009 data will be available early in 2011.

Notes - 2008
2008 natality data not yet available.

Notes - 2007
2007 data not yet available

Narrative:
All birth weight data are obtained from the MN Center for Vital Statistics. As can be seen from the most recent figures in 2008, our annual indicators have remained consistent in recent years, decreasing .4% or less for low birth weight babies (<2500 gms.) between 2005 -- 2008, and varying only .1% or less for very low birth weight babies (<1500 gms.) during the same time period. This same consistency has been observed throughout the past decade.

Despite this positive trend, however, these figures mask the discrepancy between White and non-White populations. Three-quarters (75%) of all births in Minnesota occur within the White population, compared with 18% non-White births and 8% Hispanic births. Because birth outcomes are often less positive for minority populations, the data cited above do not accurately reflect the need to address birth weight issues for non-White and ethnic populations in Minnesota.

Towards that end, we are developing new initiatives to deal with factors which may promote low birth weight. Conditions such as premature birth, late and/or inadequate prenatal care, younger or older age, periodontal health, use of chemicals (alcohol, tobacco, drugs, others) and lack of social support can be amenable to change.

One such initiative involves a recent study of 70,000+ annual births in the state of Minnesota during 2007, mapping their location by county and documenting the timing and adequacy of mothers' prenatal care, using the Kotelchuck Index. We found definite geographic variations across the state. A fact sheet and longer article will be forthcoming. Our next step is to work with local public health agencies to improve the adequacy of prenatal care throughout the state and across all populations in the state.

Macro-level factors such as socioeconomic gradients and neighborhood conditions, both social and environmental, also have an impact on low birth weight. However, these broader conditions will require a coordinated community approach beyond health itself.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	4.9	4.9	5.0	4.7	

Numerator	3339	3470	3543	3272	
Denominator	68402	70816	71102	69793	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2009
Our health status indicators, which are processed by the MN Center for Health Statistics, are usually 1 to 1-1/2 years behind the current year. Thus, 2009 data will be available early in 2011.

Notes - 2008
2008 natality data not yet available.

Notes - 2007
2007 data not yet available

Narrative:
See combined narrative for HSI 01A-B, described under section HSI 01A.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.2	1.2	1.2	1.2	
Numerator	884	856	898	871	
Denominator	70899	71344	73651	72356	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2009
Our health status indicators, which are processed by the MN Center for Health Statistics, are typically 1 to 1/12 years behind the current year. We expect that 2009 data will be available early in 2011.

Notes - 2008
2008 natality data not yet available.

Notes - 2007
2007 data not yet available

Narrative:
See combined narrative for HSI 01 A-B and HSI 02A-B, described under HSI 01A.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	0.9	0.9	0.8	0.8	
Numerator	636	632	599	587	
Denominator	68402	70416	71002	69793	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2009
Our health status indicators, which are processed by the MN Center for Health Statistics, are typically 1 to 1-1/2 years behind the current year. We expect that 2009 data will be available early in 2011.

Notes - 2008
2008 natality data not yet available.

Notes - 2007
2007 data not yet available

Narrative:
See combined narrative for HSI 01 A-B and HSI 02 A-B, described under HSI 01A.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	7.4	6.9	7.1	7.1	
Numerator	74	71	73	74	
Denominator	1005572	1030354	1035153	1035562	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2009
Our health status indicators, which are processed by the MN Center for Health Statistics, are usually 1 to 1-1/2 years behind the current year. We expect the 2009 data to be available early in 2011.

Notes - 2008

2008 injury data not available yet.

Notes - 2007
2007 data not yet available

Narrative:
Fatal Injuries

Injury data used in these reports are obtained directly from the MDH Injury and Violence Prevention Unit, which uses E-coded inpatient hospital discharge data as their source. The death rate due to unintentional injuries among children age 14 and younger was exactly the same in 2008 (most recent data available) as in 2007: 7.1 per 100,000 children in that age range. As a whole, however, this rate has fluctuated over the past seven years, declining from a high of 10 per 100,000 children in 2002 to a low of 6.9 in 2006. While outcomes in 2007-2008 are slightly higher (.2), they are still consistent with 2006 data.

The death rate due to motor vehicle crashes within that same age group (2.4 per 100,000 children) rose slightly this year (.5) after steadily falling from a high of 4.2 in 2002; however, it is still quite low. Much of this downward trend can be attributed to increased seat belt usage for younger children, as well as increased enforcement of the seat belt law in Minnesota.

MDH has been working to upgrade its data collection procedures in recent years. Improved injury outcomes reflect this effort. Coordinated processes for entering and managing hospital discharge data have reduced duplication and errors in both diagnostic codes and e-codes. Thus, the validity of reported data is based on higher standards. It is expected that MCH data quality will continue to advance in the next few years as our data systems are upgraded and further refined.

Older youth and young adults ages 15 through 24 years show a marked decrease in death from motor vehicle crashes, down from a high of 25.0 per 100,000 youth in 2003 to 19.4 in 2007, and only 12.0 per 100,000 in 2008. At this point, it is not clear why there was such a substantial drop in 2008; however, the motor vehicle death rate in this age group has been declining consistently since 2003.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	2.4	2.2	1.9	2.4	
Numerator	24	23	20	25	
Denominator	1005572	1030354	1035153	1035562	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2009

Our health status indicators, which are processed by the MN Center for Health Statistics, are usually 1 to 1-1/2 years behind the current year. We expect 2009 data to be available early in 2011.

Notes - 2008
2008 injury data not available yet.

Notes - 2007
2007 data not yet available

Narrative:
See combined narrative for HSI 03 A-C (Fatal Injuries), listed under HSI 03A.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	18.8	20.5	19.4	12.0	
Numerator	142	153	142	87	
Denominator	757328	746654	732526	726371	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2009
Our health status indicators, which are processed by the MN Center for Health Statistics, are usually 1 to 1-1/2 years behind the current year. We expect 2009 data to be available early in 2011.

Notes - 2008
2008 injury data not available yet.

Notes - 2007
2007 data not yet available

Narrative:
See combined narrative for HSI 03 A-C (Fatal Injuries), listed under HSI 03A.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	213.7	188.3	193.0	194.0	
Numerator	2149	1940	1998	2009	
Denominator	1005572	1030354	1035153	1035562	

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2009
Our health status indicators, which are processed by the MN Center for Health Statistics, are usually 1 to 1-1/2 years behind the current date. We expect 2009 data to be available early in 2011.

Notes - 2008
2008 inpatient hospital discharge data will not be available until after 1/1/10.

Notes - 2007
2007 data not yet available

Narrative:
Non-fatal Injuries

Overall, the rate of non-fatal injuries for children ages 14 years and younger in 2008 (194/100,000) is very similar to 2007 (193/100,000). This indicator showed a sharp decline in 2006 (down from 213.7 in 2005) after several years of mixed results.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	18.3	14.2	22.8	12.6	
Numerator	184	146	236	130	
Denominator	1005572	1030354	1035153	1035562	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2009
Our health status indicators, which are processed by the MN Center for Health Statistics, are usually 1 to 1-1/2 years behind the current date. We expect 2009 data to be available early in 2011.

Notes - 2008
2008 inpatient hospital discharge data (from hospitals participating in the MN Hospital Association) will not be available until at least January 2010.

Notes - 2007

2007 data not yet available

Narrative:
Non-fatal injuries requiring inpatient care due to motor vehicle crashes were noticeably higher in 2007 for all ages. At this point, it appears that 2007 was an errant year in terms of data collection and reporting procedures. After re-runs of the data this year, we determined that the correct numbers for 2007 should be 14.01/100,000 for HSI 4B and 87.51/100,000 for 4C, which puts them in proper alignment with previous as well as subsequent years.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	92.6	80.9	108.9	81.4	
Numerator	701	604	798	591	
Denominator	757328	746654	732526	726371	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2009
Our health status indicators, which are processed by the MN Center for Health Statistics, are usually 1 to 1-1/2 years behind the current date. We expect 2009 data to be available early in 2011.

Notes - 2008
2008 inpatient hospital discharge data (obtained from hospitals participating in MN Hospital Association) will not be available at least until after January 1, 2010.

Notes - 2007
2007 data not yet available

Narrative:
Non-fatal injuries requiring inpatient care due to motor vehicle crashes were noticeably higher in 2007 for all ages. At this point, it appears that 2007 was an errant year in terms of data collection and reporting procedures. After re-runs of the data this year, we determined that the correct numbers for 2007 should be 14.01/100,000 for HSI 4B and 87.51/100,000 for 4C, which puts them in proper alignment with previous as well as subsequent years.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009

Annual Indicator	17.1	17.5	18.3	19.6	19.8
Numerator	3118	3205	3347	3578	3628
Denominator	182828	182828	182828	182828	182828
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:
Data on sexually transmitted diseases are provided by the STD/HIV Section of the Infectious Disease Epidemiology, Prevention and Control Division (IDEPC) at MDH. Sexually transmitted diseases have been increasing in Minnesota in recent years; however, 2009 data show that Chlamydia--which accounts for more than three-quarters of all STDs--has begun to level off. The 2009 rate for teens, ages 15 through 19 years, is 19.8 per 100,000 persons, which is nearly identical to 2008 (19.6). The rate for older women, ages 20 through 44 years, is 7.0 for 2009, nearly identical to 2008 (7.2) and less than half the rate for teens.

Since 1996, the overall rate of Chlamydia has doubled among Whites, Hispanics, and Asians, while even greater increases are seen in Black and American Indian populations. Suburban metro areas, as well as outstate and rural Minnesota, have also seen marked expansion of Chlamydia and other STDs.

While improved testing, technology and screening practices account for a large part of earlier rate increases, there has also been an increase in actual transmission of this infectious disease, particularly among younger women. Adolescent females (ages 15-19) have two to three times the rate of Chlamydia seen in older women, a situation which is of great concern. Recently, an active MDH surveillance system has permitted identification of geographic areas and populations in greatest need of education and outreach. Hopefully the leveling off seen in 2009 will continue with additional information sharing, education, and community outreach to targeted groups by health service providers and others.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	6.2	6.5	6.8	7.2	7.0
Numerator	5603	5868	6118	6462	6324
Denominator	899814	899814	899814	899814	899814
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:

See combined narrative for HSI 05 A-B, listed under HSI 05A.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	73528	62797	5650	1348	3733	0	0	0
Children 1 through 4	284943	231885	28621	7583	16854	0	0	0
Children 5 through 9	335904	285093	26789	6611	17411	0	0	0
Children 10 through 14	341187	293281	24709	5718	17479	0	0	0
Children 15 through 19	366844	319867	24468	6464	16045	0	0	0
Children 20 through 24	359527	318323	21496	6170	13538	0	0	0
Children 0 through 24	1761933	1511246	131733	33894	85060	0	0	0

Notes - 2011

Narrative:
Population estimates, enumerated by sub-populations of age group and race/ethnicity, were provided by the MDH Center for Health Statistics and the U.S. Census Bureau (American Community Survey). According to these projections, the group comprised of infants, children, teens and young adults ages 0 to 24 years accounted for 34% or 1,761,933 of Minnesota's total population (5,220,393) in 2008, which is exactly the same proportion as 2007. Infants, children and teens ages 0 to 19 years (1,402,406) represent 27% of the 2008 state population, the same proportion as 2007. Overall population in Minnesota increased by only .4% in 2008.

However, diversity continues to expand steadily. State population estimates for 2008 indicate that 85.8% of young Minnesotans (ages 0 through 24 years) are White, 7.5% are Black, 4.8% are Asian, and 1.9% are American Indian. In addition, an estimated 6.2% of the state population is Hispanic. Within the Twin Cities metropolitan area of St. Paul and Minneapolis, populations of color and Hispanics represent a somewhat larger proportion of total residents.

Statistics cited above suggest that Minnesota's overall population demographics have changed very little in the past few years. Because these data are only projections, little can be said with respect to concrete changes. The 2010 census should provide additional hard data. It is clear, however, that there continues to be greater diversity in Minnesota, and with this diversity, increasing challenges for Title V programs to introduce culturally appropriate strategies that target the varied set of needs appropriate for this growing segment of our population.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	67223	6305	0
Children 1 through 4	258392	26551	0
Children 5 through 9	310881	25023	0
Children 10 through 14	321140	20047	0
Children 15 through 19	350436	16408	0
Children 20 through 24	343926	15601	0
Children 0 through 24	1651998	109935	0

Notes - 2011

Narrative:
See combined narrative for HSI 06 A-B, listed under HSI 06A.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	65	11	24	6	13	0	0	11
Women 15 through 17	1377	643	288	110	127	0	0	209
Women 18 through 19	3501	2079	569	216	231	0	0	406
Women 20 through 34	56999	43103	5068	1133	3847	0	0	3848
Women 35 or older	10439	8133	879	90	771	0	0	566
Women of all ages	72381	53969	6828	1555	4989	0	0	5040

Notes - 2011

Narrative:
Birth data are compiled by the MDH Center for Health Statistics from hospital birth records and Vital Statistics data. Live births in the state of Minnesota decreased from 73,675 infants in 2007 to 72,381 infants in 2008, a reduction of 1.8%. The birth rate also declined from 14.2 in 2007 to 13.9 in 2008.

Subpopulations which showed an increase in 2008 births were: Blacks, 2.5% additional births (6,828 compared with 6,660 in 2007); American Indians, 2.6% more births (1,555 compared to 1,516 in 2007); Asians, 0.4% more births (4,989 compared to 4,971 in 2007). The only two population groups which showed a decline in 2008 births were Whites (-2.5%) and Hispanics (-3.1%).

As might be expected, the largest number of births occurred to women between the ages of 20 through 34 years, both overall as well as across all racial and ethnic categories. More than three-quarters (79%) of all 2008 births were born to women in this age group. Overall, women age 35 or older had the second highest number of births, accounting for 14% of all infants born in 2008. Young women under the age of 20 made up the remaining 7% of births. These statistics may be indicative of a statewide trend to delay childbearing beyond teen and early working years, particularly among Minnesota's sizeable White population.

An exception to this pattern was seen among Native American women, where girls ages 15 through 19 years had the second highest number of births in this subgroup. Because young girls in their teens often give birth to low birthweight babies (<2500 gms.) or very low birthweight babies (<1500 gms.), the high proportion of such births within the Native American community is of considerable concern. Further, young teens often have inadequate prenatal care and are especially vulnerable to complications of pregnancy and childbirth. MDH is addressing this issue by working directly with American Indian leaders, as well as producing educational materials and workshops for local public health agencies and service providers, who can then work more effectively with their young people.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	47	17	1
Women 15 through 17	1081	269	27
Women 18 through 19	2961	511	29
Women 20 through 34	52002	4359	638
Women 35 or older	9721	567	151
Women of all ages	65812	5723	846

Notes - 2011

Narrative:
See combined narrative for HSI 07 A-B (Live Births), listed under HSI 07A.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	433	266	94	18	25	0	0	30
Children 1 through 4	80	55	14	3	2	0	0	6
Children 5	41	26	7	3	1	0	0	4

through 9								
Children 10 through 14	45	34	6	3	1	0	0	1
Children 15 through 19	132	101	16	5	5	0	0	5
Children 20 through 24	244	184	31	10	11	0	0	8
Children 0 through 24	975	666	168	42	45	0	0	54

Notes - 2011

Narrative:
Vital Statistics records maintained by the MDH Center for Health Statistics are the source for data on infant and child deaths in Minnesota. During 2008 a total of 975 deaths were recorded for infants, children, and young adults ages 0 through 24 years, which is 10 fewer than 2007 (985 deaths). As might be expected, the greatest proportion of those deaths (44%) occurred to infants less than one year of age (n=433), overall as well as across all racial and ethnic groups.

Minnesota's infant mortality rate (0 to age 1) has been edging slightly upward over the past few years, ranging from 4.7 deaths per 1,000 live births in 2003 to 5.5 in 2007 and 6.0 in 2008. Reasons for this increase are not totally clear. However, it is noteworthy that White babies have the lowest proportion of deaths in the 0 to 1 age group (40%) when compared with other racial/ethnic groups. Black and Asian populations each have 56% of infant/child deaths occur before these children reach their first birthday, while 54% of Hispanic child deaths occur before age one. Perhaps the community education MDH has done with local providers, particularly around the issue of adequate prenatal care, has influenced positive outcomes for White women. Follow-up assessments are planned. It is clear, however, that additional work needs to be done with Black, Asian and Hispanic populations.

The second largest proportion of deaths in 2008 (25%) occurred in the young adult population between 20-24 years, which is slightly lower than 2007 (27%). This age group, when combined with teens ages 15-19, accounts for 39% of all 2008 deaths for persons 0-24 years of age. This percentage is also lower than previous years (44% in 2007). Racial/ethnic variations appear in this older age group as well.

The Hispanic population had the lowest proportion of older child/young adult deaths (22%) in 2008, while the White population had the highest (43%). Many deaths in this older age range are due to preventable and/or self-inflicted injuries such as motor vehicle crashes, suicides, and drug/alcohol related issues. While this is an age group which often does not respond well to intervention, nonetheless new strategies are needed to reduce these unnecessary deaths, particularly among White youths.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	387	41	5
Children 1 through 4	71	9	0
Children 5 through 9	35	6	0

Children 10 through 14	42	3	0
Children 15 through 19	123	8	1
Children 20 through 24	234	9	1
Children 0 through 24	892	76	7

Notes - 2011

Narrative:
See combined narrative for HSI 08 A-B, listed under HSI 08A.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	1402406	1192923	110237	27724	71522	0	0	0	2008
Percent in household headed by single parent	33.0	20.0	62.0	0.0	29.0	0.0	0.0	0.0	2007
Percent in TANF (Grant) families	5.1	2.2	27.4	34.6	9.7	0.0	8.6	15.8	2008
Number enrolled in Medicaid	430811	244476	86910	18209	29990	0	17249	33977	2009
Number enrolled in SCHIP		0	0	0	0	0	0	0	2009
Number living in foster home care	13755	6839	2950	1798	329	4	1220	615	2008
Number enrolled in food stamp program	236047	115141	67645	13897	18145	0	12385	8834	2009
Number enrolled in WIC	139405	80011	28825	5602	11962	220	12782	3	2009
Rate (per 100,000) of juvenile crime arrests	3368.0	2358.0	13990.0	6915.0	2461.0	0.0	0.0	0.0	2008
Percentage of high school drop-outs (grade 9 through 12)	6.3	4.1	13.1	20.2	6.6	0.0	0.0	0.0	2008

Notes - 2011
Sample size for American Indian population was too small to calculate a valid percentage.

MN does not have an active SCHIP program at this time.

Age range: 0 - 18 years

Narrative:
US Census Bureau data, obtained from the American Community Survey, show that 1,402,406 infants and children ages 0 through 19 years lived in Minnesota in 2008--a .1% reduction in this population since 2007. These figures are compatible with a total estimated population increase of only .4% and an unchanged birth rate during 2008. Projection estimates also indicate that Minnesota children are predominantly White (85.1%), with 7.9% Black, 5.1% Asian, and 2.0% American Indian; 6.7% identify as Hispanic. This distribution is nearly identical to 2007.

One-third (33%) of children ages 0 through 19 were living in households headed by single parents, an increase of 12% over 2007. Black families had the highest percentage of children in single-parent households (62%), similar to the preceding year.

According to the Department of Human Services there were 13,755 children ages 0-18 years in out-of-home placements, the majority of whom were living in foster homes. While the greatest number of infants and children in foster care were White (6,839) Blacks and children of two or more races were 4-5 times more likely than White children to be placed outside their home. American Indian children were 12 times more likely to be in out-of-home placements. This is a disturbing trend and an important concern in Minnesota.

Department of Human Services data show that 5.1% of children ages 0 -19 (n=71,583) lived in families receiving TANF grants (2008) while 30.7% (n=430,811) were enrolled in Medicaid (2009). American Indians had the highest percentage of families on TANF (23.5%) with Black families next at 22.9%. Only 2.2% of White families were enrolled on TANF in 2008. Approximately one-fifth (20.5%) of the White children were enrolled on Medicaid. In contrast, more than three-quarters (78.8%) of Black children and nearly two-thirds (65.7%) of American Indian children were enrolled in Medicaid.

Minnesota's food stamp program enrolled 236,047 persons in 2009, or 16.8% of all children 0 -19 years, almost identical to last year's enrollment of 17%. White children received nearly half (48.8%) of all food stamps compared with 47% last year. Blacks and American Indians received 28.7% and 5.9%, respectively. Within their individual populations, 61.4% of Black children, 50% of American Indians and 9.7% of White children received food stamps.

WIC enrolled 139,405 children under age five in its nutrition program, more than half (57.4%) of whom were White; 20.7% were Black, 8.6% Asian, 4% American Indian and 9.2% mixed racial heritage.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY	Total NOT	Total	Ethnicity Not	Specific

Miscellaneous Data BY HISPANIC ETHNICITY	**Hispanic or Latino**	**Hispanic or Latino**	**Reported**	**Reporting Year**
All children 0 through 19	1308072	94334	0	2008
Percent in household headed by single parent	0.0	41.0	0.0	2007
Percent in TANF (Grant) families	11.3	4.7	0.0	2008
Number enrolled in Medicaid	376213	54598	0	2009
Number enrolled in SCHIP	0	0	0	2009
Number living in foster home care	88366	1250	0	2008
Number enrolled in food stamp program	208804	27243	0	2009
Number enrolled in WIC	139405	33245	0	2009
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	0.0	2008
Percentage of high school drop-outs (grade 9 through 12)	0.0	16.2	0.0	2008

Notes - 2011
Age range: 0 to 18 years.

MN does not have an active SCHIP program in the state at this time.

It is not possible to separate out Hispanic juvenile crime from all other juvenile crime arrests at this time. The MN Dept. of Public Safety is upgrading their juvenile crime data system, and it is likely that we will be able to calculate this measure next year.

It is not possible to calculate an accurate figure for non-Hispanic high school dropouts without double-counting some Hispanic children. The MN Dept. of Education web site is currently being revised, and next year we will likely be able to calculate this measure fully.

Narrative:
US Census Bureau data, obtained from the American Community Survey, show that 94,334 infants and children ages 0 through 19 years who identify their ethnicity as Hispanic or Latino resided in Minnesota during 2008. Projection estimates indicate that 6.7% of Minnesota's children are Hispanic.

The Minnesota Department of Human Services reports that there were 13,755 children ages 0-18 years in out-of-home placements during 2008, the majority of whom were living in foster homes. Demographic figures indicate that 1,250 Latino or Hispanic children were living in foster care, or slightly more than 1% of this population.

In addition, 10.9% of Hispanic children were living in families who received TANF grants in 2008. While this percentage does not compare favorably with children living in White households, where only 2.2% of children received TANF funds, nonetheless it is substantially better than American Indian or Black children who had the highest percentage of children in TANF families, 23.5% and 22.9%, respectively.

More than half of Hispanic children (57.9%) were enrolled in Medicaid in 2008, which is nearly double the proportion (30.7%) of all children in Minnesota ages 0 through 19 receiving health care through Medicaid that year.

More than one-fourth (28.9%) of all Hispanic children participated in the food stamp program, compared with 16.8% of all Minnesota children ages 0-19 years. In addition, the WIC program enrolled 33,245 Hispanic children, or 35.2% of that population, which is an encouraging indicator.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	867362
Living in urban areas	351571
Living in rural areas	35711
Living in frontier areas	0
Total - all children 0 through 19	387282

Notes - 2011
We are unable to obtain data for children who are age 18 or beyond. Thus, data for this indicator are based on children from birth up to 18 years, or 0 - 18 years.

Narrative:
The Children's Defense Fund, in collaboration with the Annie E. Casey Foundation, estimates that the total number of children ages 0 -- 18 years living in the state of Minnesota is 1,254,644. Geographic distribution shows that 867,362, or 69% of Minnesota's child/teen population, live in the seven-county metro area surrounding and including the cities of St. Paul and Minneapolis.

There are many smaller cities and urban areas throughout the state, accounting for an additional 351,571 or 28% of Minnesota's children. The balance, 35,711 persons, or 3% of all children ages 0-18, live in rural or semi-rural areas of the state. Minnesota also has eleven American Indian reservations--nine of which are located on large parcels of land in northern and/or rural areas of the state--which are home to many Native American children. Seven reservations belong to the Chippewa (Ojibwe) tribe, and four are Dakota tribes, two of which are located in close proximity to the metro area. There are no frontier areas in Minnesota.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	5090468.0
Percent Below: 50% of poverty	4.1
100% of poverty	14.5
200% of poverty	16.0

Notes - 2011

Narrative:
The total Minnesota state population for whom poverty status was determined by the U.S. Census Bureau in 2008 is 5,090,468. Of this total population (including both adults and children) it is estimated that 211,005 persons, or 4.1%, were living at 50% below the federal poverty level (FPL), as calculated from American Fact Finder (File C17024). An additional 738,879, or 14.5%, were living at 100% of poverty, and 814,113 (16.0%) were living at 200% of poverty.

In 2008 there were 1,254,644 children under the age of 18 years in Minnesota; 61,000 or 4.9% of these children were living at 50% below FPL. An additional 140,000, or 11.2% were at 100% FPL, and 359,000, or 28.6%, were at 200% FPL. According to the Children's Defense Fund, Kids Count Data Book (2009), "…it is likely that between 193,000 and 205,000 [Minnesota] children will fall below the poverty line before the economy recovers." For many of these children, rising out of poverty will be very difficult, depending on the availability of education and social resources. It is hoped that MDH, in conjunction with the MN Department of Human Services, local non-profit agencies and community leaders, will be able to provide some of these resources and training as the economy recovers.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	1254644.0
Percent Below: 50% of poverty	4.9
100% of poverty	11.2
200% of poverty	28.6

Notes - 2011
We are unable to obtain data for children who have reached the age of 18 and beyond. These data apply to children from birth up to age 18, or 0-18 years of age.

Narrative:
See combined narrative for HSI #11 and HSI #12, listed under HSI #11.

F. Other Program Activities

Toll-free Telephone Numbers -- For parents and others, the Minnesota Title V programs assure toll-free telephone access to information about health care providers and practitioners who provide health care services under Titles V and XIX and about other relevant health and health-related providers and practitioners. Title V programs accomplish the intent of this requirement by improving the effectiveness of previously established special purpose toll-free arrangements.

1) The Title V CYSHCN has operated a toll-free Information and Assistance telephone line since March of 1990. This line offers a comprehensive listing of services provided by state and county health and human services departments, hospitals, associations, family support groups and allied public and private entities. The toll-free number is included on all educational and information publications developed and is included in all media announcements.

2) The Department of Human Services consumer services call center 800 number handles questions related to obtaining prenatal care services from Medical Assistance or MinnesotaCare. Calls related to prenatal health and other maternal and child health matters are referred by the Department of Human Services to the Title V program to be addressed. Information regarding obtaining prenatal services and related questions can also be accessed via the MDH or DHS web sites.

3) The MinnesotaCare program provides an automated state toll-free line that operates 24 hours a day, seven days a week. The toll-free number will provide the caller with general information about the plan, qualifications for acceptance and application information. The automated message is available in seven languages including Spanish, Hmong, Somali, Vietnamese, Laotian, Bosnian, and Russian. All outreach materials distributed by the Department of Human Services include this state toll-free number for individuals to call with questions.

4) The Minnesota Family Planning and STD hotline is staffed by individuals trained in information and referral as well as family planning and STD counseling. All family planning and STD related educational materials distributed by the Minnesota Department of Health include the hotline number. Annually, information about family planning which includes the hotline number is mailed to all Medicaid/MinnesotaCare recipients.

5) The WIC Program 800 number is funded through Minnesota's federal WIC grant and provides 24 hour -- 365 days a year phone coverage. Callers are provided with the business telephone number of the local WIC project in their geographic area. All WIC outreach materials distributed include the 800 number. There is also a WIC supported specialized line related to breastfeeding.

G. Technical Assistance

Form 15 outlines the technical assistance needs identified by the Title V programs for the upcoming year. Additional discussions will be occuring internally to determine priorities, timing and suggested TA providers.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	9043482	9072643	9073569		9072643	
2. Unobligated Balance *(Line2, Form 2)*	842441	2560	811024		384363	
3. State Funds *(Line3, Form 2)*	7032333	6806402	7032333		7032333	
4. Local MCH Funds *(Line4, Form 2)*	3248335	3697877	3560507		3704946	
5. Other Funds *(Line5, Form 2)*	5420487	6217417	6269070		6587720	
6. Program Income *(Line6, Form 2)*	50782	78571	68247		78571	
7. Subtotal	25637860	25875470	26814750		26860576	
8. Other Federal Funds *(Line10, Form 2)*	131916672	141927894	155303472		147421896	
9. Total *(Line11, Form 2)*	157554532	167803364	182118222		174282472	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	6643864	5604170	5651951		5696238	
b. Infants < 1 year old	2320999	3465098	3038619		3522025	

c. Children 1 to 22 years old	6225679	6815488	7290870		6971376	
d. Children with Special Healthcare Needs	8802367	8452430	8782537		9023895	
e. Others	793951	833349	1225773		847042	
f. Administration	851000	704935	825000		800000	
g. SUBTOTAL	25637860	25875470	26814750		26860576	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	87500		150000		300000	
b. SSDI	94644		94644		100000	
c. CISS	140000		105000		132000	
d. Abstinence Education	0		0		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	124576089		143584571		136511917	
h. AIDS	0		0		0	
i. CDC	1756322		149957		147997	
j. Education	512250		300000		0	
k. Other						
ED	0		0		255000	
HRSA	4598815		10419300		9974982	
HHS	0		500000		0	
PRAMS	151052		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	8805335	11410292	10795155		11351551	
II. Enabling Services	4331061	3409894	3464458		4131189	
III. Population-Based Services	6364720	7170468	7033232		6032603	
IV. Infrastructure Building Services	6136744	3884816	5521905		5345233	
V. Federal-State Title V Block Grant Partnership Total	25637860	25875470	26814750		26860576	

A. Expenditures

Please see Forms 3-5 and appropriate related notes.

B. Budget

Please see Forms 3-5 and appropriate related notes.

B. Budget

Oversight of the Title V, MCH Block Grant is the responsibility of the Division of Community and Family Health. The language in Minnesota Statutes Chapter 145.88 distributes two-thirds of Minnesota's federal MCH Block Grant funding (approximately $6.1 million) by formula to Community Health Boards (CHBs), Minnesota's local public health structure. The boards are comprised of elected officials, either county commissioners or city council members. They are responsible for policy formulation and oversight of the local public health administrative agencies which conduct core public health functions. State law requires CHBs to provide at least a 50 percent match for federal MCH Block Grant funds received each year. CHBs predominately use local tax dollars and some state grant dollars to meet their required match.

The legislation directs funding to be used for high risk and low-income individuals who 1) have a high rate of infant mortality and children with low birth weight, 2) target pregnant women who have an increased likelihood of complications during pregnancy, 3) address the health needs of young children who have or are likely to have a chronic disease or disability or special health need, 4) provide family planning services, 5) address the frequency and severity of childhood and adolescent health issues, 6) address preventing child abuse and neglect, reducing juvenile delinquency, promoting positive parenting and resiliency in children, and promoting family health and economic sufficiency through public health nurse home visiting and 7) address nutritional issues of women, infants and young children through WIC clinic services. The Division of Community and Family Health, which houses the Title V programs, has responsibility to provide fiscal oversight and technical assistance to CHBs in the use of these federal dollars.

CHBs are required to report annually on their proposed budgets and expenditures of the federal MCH Block Grant. The approximately $6.1 million provided to the 53 CHBs represents approximately 2 percent of their total funding available for public health efforts. However, this percent of total funding is an average and does not reflect the wide variance between CHBs and their total budgets. The range of Title V MCH Block Grant funding to their total available funding is 1 percent to 6 percent, with the average being 2 percent. One issue with the distribution of a significant portion of the MCH Block Grant in this manner is that the 53 CHBs redirect these funds to where they are most needed to maintain local core maternal and child health services. This causes a constant fluctuation in populations served, total numbers of individuals served, and type of services provided resulting in frequent changes in block grant data reporting greater than 10 percent.

State law allows one-third of the federal MCH Block Grant to be retained at the state to: 1) meet federal maternal and child health block grant requirements of a five year needs assessment and to prepare annual federal block grant applications and annual plans, 2) collect and disseminate statewide data on the health status of mothers and children, 3) provide technical assistance to Community Health Boards, 4) evaluate the impact of maternal and child health activities on the health status of mothers and children, 5) provide services to children under age 16 receiving benefits under title XVI of the Social Security Act; and 6) perform other maternal and child health activities. Indirect charges for the total MCH Block grant are included in this portion of the funding.

Currently, the MCH Block Grant supports a total of 25 FTEs within the Division of Community and Family Health, twelve of which are located in the children and youth with special health needs program. The maternal and child health and children and youth with special health needs sections efforts are augmented with additional funding received from other federal grants (HRSA -- SSDI, Loss to Follow-up and SECS grants, CDC -- FAS, PRAMS, BDIS and Preventive Block Grant funds which are directed at Suicide Prevention activities) and from various state (state general funds, newborn screening fees, marriage license fees, and Health Care Access Funds) and federal funds (Medicaid match and TANF funding as well as Department of Education Part C and Part B funding).

Other federal sources of funds that are administered by the Division of Community and family

Health include Preventive Block Grant funds ($600,000) directed at providing public health technical assistance to CHBs and Department of Agriculture funds ($124,576,000 - which includes formula rebate funds) supports the WIC program, Commodity Food Supplemental Program and a small Breastfeeding Peer Support grant.

State appropriations used to support programs within the Division of Community and Family Health comes to over $32 million with the primary portion ($21 million) going to CHBs through the Local Pubic Health Grant. State funds support Division administration including the CYSHCN and MCH managers, family planning services, technical assistance to local CHBs, CYSHCN grants, FAS prevention, newborn screening follow-up and intervention, Women's Right to Know, Family Home Visiting program, Positive Alternatives Program, Suicide Prevention, infant mortality, hearing aid loaner bank, parent to parent support services for families with young children who are deaf or have a hearing loss, Birth Defects Information System and technical assistance to local public health agencies.

The source of matching funds for the Title V Block Grant comes from both state and local sources. As mention earlier, CHBs are required to provide a 50% match for the federal Title V funding they receive. Additional federal match requirements are met by state funds administered by the Division of Community and Family Health that support MCH and CYSHCN program efforts. The largest of these efforts it the state funded Family Planning Special Projects Grants.

Minnesota's maintenance of effort from 1989 is $6,184,197. The budget documents that Minnesota continues to maintain this level of effort.

Additional program areas impacting the health of mothers and children, including children and youth with special health care needs located in other areas of the Minnesota Department of Health include: newborn screening program (Laboratory Division), reducing disparities in infant mortality and teen pregnancy prevention (Office of Minority and Multicultural Health), lead screening and Enviornmental Registry (Environmental Health), tobacco, alcohol and childhood injury prevention (Health Promotion and Chronic Disease) and immunizations and refugee health (Infectious Disease, Epidemiology, Prevention and Control Division). Funds supporting these programs are in addition to those outlined in this application. While Title V staff collaborates and work closely with these programs, no federal Title V funds are used directly to support these activities nor are any of these activities currently used to meet Minnesota's match or maintenance of effort.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section “New State Performance Measure Detail Sheets and Data.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.